Alliance Christian Academy DATE OF EXAM:

Pre-participation Medical History

The medical History form must be completed every school year by the parent (or guardian) and student in order for the student to participate in athletic activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an athletic event.

Student’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grade \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sex \_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_

Explain “Yes” answers on an additional sheet. Circle questions you don’t know the answers to. Any yes answer to questions 1, 2, 5-15, 17-22, 29 or 37 requires further medical evaluation which may include a physical examination. Written clearance from a physician, physician assistant, or nurse practitioner is required before any participation in CSAF/TCAF practices, games or matches.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Yes | No |  | Yes | No |
| 1. Have you had a medical illness or injury since your last check up or sports physical?2. Have you been hospitalized overnight in the past year?3. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?4. Do you have any allergies (for example, to pollen, medicine, food or stinging insects)?5. Have you ever passed out during or after exercise?6. Have you ever been dizzy during or after exercise?7. Have you ever had chest pain during or after exercise?8. Do you get tired more quickly than your friends do during exercise?9. Have you ever had racing of your heart or skipped heartbeats?10. Have you had high blood pressure or high cholesterol?11. Have you ever been told you have a heart murmur?12. Has any family member or relative died of heart problems or of sudden unexpected death before age 50?13. Has any family member been diagnosed with enlarged heart, hypertrophic cardiomyopathy, long QT syndrome, Marfan’s syndrome, or abnormal heart rhythm?14. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?15. Has a physician ever denied or restricted your participation in sports for any heart problems?16. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?17. Have you ever had a head injury or concussion?18. Have you ever been knocked out, become unconscious, or lost your memory? If yes, how many times?\_\_\_\_\_\_\_\_\_\_\_\_\_  When was the last concussion? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How severe was each one? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_19. Have you ever had a seizure?20. Do you have frequent or sever headaches?21. Have you ever had numbness or tingling in your arms, hands, legs, or feet?22. Have you ever had a stinger, burner, or pinched nerve?23. Have you ever become ill from exercising in the heat?24. Have you ever gotten unexpectedly short of breath with exercise?25. Do you cough, wheeze, or have trouble breathing during or after activity?26. Do you have asthma?27. Do you have seasonal allergies that require medical treatment?An individual answering in the affirmative to any question relating to a possible cardiovascular health issue (questions 5-15 above), as identified on the form, should be restricted from further participation until the individual is examined by the individual’s primary care physician. Ultimately, the individual may need to be evaluated by a cardiologist and/or undergo cardiac testing (including echocardiogram and/or other heart-related examinations) based on the assessment by the primary care physician. | □□□□□□□□□□□□□□□□□□□□□□□□□□□ | □□□□□□□□□□□□□□□□□□□□□□□□□□□ | 28. Have you had any problems with your eyes or vision?29. Are you missing any paired organs?30. Do you use any special protective or corrective equipment or devices that aren’t usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?31. Have you ever had a sprain, strain, or swelling after injury?32. Have you broken or fractured any bones or dislocated any joints?33. Have you had any other problems with pain or swelling in your muscles, tendons, bones, or joints? If yes, check appropriate box and explain below. □ Head □ Elbow □ Hip □ Neck □ Forearm □ Thigh □ Back □ Wrist □ Knee □ Chest □ Hand □ Shin □ Shoulder □ Finger □ Calf □ Upper Arm □ Foot □ Ankle34. Do you want to weigh more or less than you do now?35. Do you lose weight regularly to meet weight requirements for your sport?36. Do you feel stressed out?37. Record the dates of your most recent immunizations for : Tetanus \_\_\_\_\_\_\_ Measles \_\_\_\_\_\_\_\_\_ Hepatitis B \_\_\_\_\_\_ Chickenpox \_\_\_\_\_\_\_38. Are you under a doctor’s care? | □□□□□□□□□□□ | □□□□□□□□□□□ |
| **Females only:**39. When was your first menstrual period? \_\_\_\_\_\_\_\_\_\_\_40. When was your most recent menstrual period? \_\_\_\_\_\_\_\_\_\_\_41. How much time do you usually have from the  start of one period to the start of another? \_\_\_\_\_\_\_\_\_\_\_42. How many periods have you had in the last year? \_\_\_\_\_\_\_\_\_\_\_43. What was the longest time between periods in the last year? \_\_\_\_\_\_\_\_\_\_\_\_\_ |

It is understood that even though protective equipment is warn by the athlete, whenever needed, the possibility of an accident still remains. Neither TCAF, CSAF nor Alliance Christian Academy assumes responsibility in case an accident occurs.

If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given said student by any physician, athletic trainer, nurse or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student.

If, between this date and the beginning of athletic competition, any illness or injury should occur that may limit this student’s participation, I agree to notify the school authorities of such illness or injury.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Student Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alliance Christian Academy

Pre-participation Physical Evaluation & Examination

Student’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex \_\_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height \_\_\_\_\_\_ Weight \_\_\_\_\_\_ %Body fat (optional) \_\_\_\_\_\_ Pulse \_\_\_\_\_\_\_ BP \_\_\_\_\_/\_\_\_\_\_(\_\_\_\_\_/\_\_\_\_\_, \_\_\_\_\_/\_\_\_\_\_)

Vision: right - 20/\_\_\_\_\_\_\_ left - 20/\_\_\_\_\_\_\_ Corrected: Yes or No Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

Hearing: right \_\_\_\_\_\_\_\_\_\_ left\_\_\_\_\_\_\_\_\_\_\_\_

As a minimum requirement, this **Physical Evaluation & Examination** form must be completed prior to athletic participation every year. It ***must*** be completed if there are yes answers to specific questions on the student’s **Medical History** form. Local district policy may require an annual physical exam.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Normal | Abnormal Findings | Initials \* |
| **MEDICAL** |  |  |  |
| - Appearance |  |  |  |
| - Eyes/Ears/Nose/Throat |  |  |  |
| - Lymph Nodes |  |  |  |
| - Heart-Auscultation of the heart in the supine position |  |  |  |
| - Heart-Auscultation of the heart in the standing position |   |  |  |
| - Heart-Lower extremity pulses |  |  |  |
| - Pulses |  |  |  |
| - Lungs |  |  |  |
| - Abdomen |  |  |  |
| - Genitalia (males only) |  |  |  |
| - Skin |  |  |  |
| **MUSCULOSKELETAL** |  |  |  |
| - Neck |  |  |  |
| - Back –check for Scoliosis |  |  |  |
| - Shoulder/Arm |  |  |  |
| - Elbow/Forearm |  |  |  |
| - Wrist/Hand |   |  |  |
| - Hip/Thigh |  |  |  |
| - Knee |  |  |  |
| - Leg/Ankle |  |  |  |
| - Foot |  |  |  |

\* station-based examination only

**CLEARANCE**

□ Cleared

□ Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Not cleared for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Recommendations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The following information must be filled in and signed by either a physician, physician assistant licensed by a State Board of Physician Assistant Examiners, a registered nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination forms signed by any other health care practitioner will not be accepted.

Name (print/type) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of examination \_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Must be completed before a student participates in any practice, before, during or after school, both in season or out of season, or in games/matches.