ARKADELPHIA PUBLIC SCHOOLS PRE-PARTICIPATION

HISTORY & PHYSICAL SCREENING

Name:_____ Sex: ☐F ☐M Age:_____ Date of Birth:_____/_____/_____
Current Grade:____ Current School:_____ Sport(s) Please list ALL:_____
Physical Address:_____ Phone(s):_____
Personal Physician:_____ Physician Phone:_____ ☐None
Emergency Contact Name(s)_____Relationship(s):_____ Phone(s):_____

Attention parent or guardian and athlete: answers to the following questions are very important!
Please take the time, read through the questions, and answer to the best of your knowledge on both sides of the form.

General Medical History

1. Do you have seizures?	Yes ☐	No ☐
2. Do you have diabetes?	Yes ☐	No ☐
3. Do you have high blood pressure?	Yes ☐	No ☐
4. Do you take medicine for high blood pressure?	Yes ☐	No ☐
5. Do you have sickle cell trait?	Yes ☐	No ☐
6. Have you had a concussion within the last year?	Yes ☐	No ☐
7. Do you have any other major medical problem(s)?	Yes ☐	No ☐

STOP! If you answered YES to any of the above questions, your child will not be cleared through the school physical screening and must see their personal physician. If you answered NO to ALL questions, please, continue below.

7. Do you have asthma?	Yes ☐	No ☐
8. Do you use an inhaler?	Yes ☐	No ☐
9. Do you cough, wheeze or have trouble breathing with exercise?	Yes ☐	No ☐
10. Have you ever been hospitalized or had surgery?	Yes ☐	No ☐
11. Do you have a single organ (testicle, kidney)?	Yes ☐	No ☐
12. Do you have any allergies? (seasonal, insects, food, or medicines)?	Yes ☐	No ☐
13. Have you ever had a rash or hives develop during or after exercise?	Yes ☐	No ☐
14. Do you have any skin problems other than acne?	Yes ☐	No ☐
15. Have you ever had a head injury, been knocked out, lost your memory, or a concussion?	Yes ☐	No ☐
16. Have you ever had numbness or tingling in your arms, hands, legs, or feet?	Yes ☐	No ☐
17. Have you ever had a stinger, or pinched nerve?	Yes ☐	No ☐
18. Have you ever become ill from exercising in the heat?	Yes ☐	No ☐
19. Do you feel stressed out, tired, or depressed?	Yes ☐	No ☐
20. Are there any other issues you'd like to discuss today?	Yes ☐	No ☐
21. Are your immunizations up-to-date?	Yes ☐	No ☐

Females Only

1. Are your periods regular (every month)?	Yes ☐	No ☐
2. Are your periods heavy?	Yes ☐	No ☐

Medication

1. Are you currently taking any medicines or do you take any medicines on a regular basis (prescription or over-the-counter)? Yes ☐ No ☐

List all medication (prescription or over the counter) you are currently taking including dosage amount and frequency :_____

_____

Cardiac History

1. Do you have a chronic heart condition?	Yes ☐	No ☐
2. Do you have high blood pressure?	Yes ☐	No ☐
3. Do you take medication related to a heart condition or high blood pressure?	Yes ☐	No ☐

STOP! If you answered YES to any of the above questions, your child will not be cleared through the school physical screening and must see their personal physician. If you answered NO to ALL questions, please, continue below.

4. Have you ever passed out during or after exercise?	Yes ☐	No ☐
5. Have you ever been dizzy during or after exercise?	Yes ☐	No ☐
6. Have you ever had chest pain or chest pressure during exercise?	Yes ☐	No ☐
7. Do you tire easily or more quickly than your friends during exercise?	Yes ☐	No ☐
8. Have you ever had racing of your heart or skipped heartbeats?	Yes ☐	No ☐
9. Have you ever been told you have a heart murmur?	Yes ☐	No ☐
10. Have you ever been told you had an enlarged or weak heart?	Yes ☐	No ☐
11. Has any member of your family:		
-died of heart problems or sudden death before age 50?	Yes ☐	No ☐
-been told they had serious heart problems before age 50?	Yes ☐	No ☐
-been told they had Marfan's syndrome?	Yes ☐	No ☐
12. Has a physician ever denied or restricted your participation in sports?	Yes ☐	No ☐

Orthopedic History

1. Do you have a chronic orthopedic condition or abnormality?	Yes ☐	No ☐

STOP! If you answered YES to any of the above questions, your child will not be cleared through the school physical screening and must see their personal physician. If you answered NO to ALL questions, please, continue below.

2. Have you ever broken or fractured any bones?	Yes ☐	No ☐
3. Have you ever subluxed or dislocated any joint?	Yes ☐	No ☐
4. Have you had any other joint related problems?	Yes ☐	No ☐

If yes, where_____

Vision, Hearing, and Weight

1. Do you have trouble with your eyes/vision/wear glasses?	Yes ☐	No ☐
2. Do you have trouble with hearing/wear hearing aids?	Yes ☐	No ☐
3. Do you want to weigh more or less than you do now?	Yes ☐	No ☐
4.Do you lose weight regularly to meet weight requirements for your sport or other reason?	Yes ☐	No ☐
5. Have you ever taken any supplements or vitamins to help with weight loss, weight gain or improve performance?	Yes ☐	No ☐

Explain "YES" answers here to any of the above questions (attach additional paperwork if needed). Please give dates of any injuries, surgeries, or onset of medical conditions:

Turn form over and complete the back.

Name:_____ Date of Birth:____/____/_____ Current Grade:_____

Parent's Permission & Acknowledgement of Risk for Son or Daughter to Participate in Athletics

As the parent or legal guardian of the above named student athlete, I give my permission for his/her participation in athletic events and the physical evaluation screening for that participation. I understand that this is simply a screening evaluation and not a substitute for regular health care. I also grant permission for treatment deemed necessary for a condition arising during participation of these events, including medical or surgical treatment that is recommended by a medical doctor. I grant permission to nurses, trainers, and coaches; as well as, physicians or those under their direction who are part of athletic injury prevention and treatment, to have access to necessary medical information. I know that the risk of injury to my child/ward comes with participation in sports and during travel to and from play and practice. I have had the opportunity to understand the risk of injury during participation in sports through meetings, written information, or by some other means. My signature indicates that to the best of my knowledge, my answers to the above questions are complete and correct. I understand that the data acquired during these evaluations may be used for research purposes.

Signature of athlete_____ Date_____

Signature of parent/guardian_____ Date_____

Pre-Screen

Height :_____ inches (with shoes on) Weight:_____ pounds (with shoes on)	BP: Right __________ Pulse:_____ automatic ☐ manual ☐ Left __________ Pulse:_____ automatic ☐ manual ☐ **Wait 5 minutes & recheck both arms manually if BP over 130/80** Right __________ Left __________ Pulse:_____

Physical Screening

Medical		Normal	Abnormal Findings	Initials*
Appearance				
Eyes/Ears/Nose/Throat				
Lymph Nodes				
Heart	Pericardial Activity			
	1st & 2nd Heart Sounds			
	Murmurs			
Lungs				
Skin				
Musculoskeletal				
Neck				
Back				
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:_____
_____

Name of physician (Print/Type):_____ Date:____/_____/_____
Address:_____ Phone: (____)_____
Signature of Physician: _____