

# THE SOUTH CAROLINA INDEPENDENT SCHOOL ASSOCIATION

## Pre-Participation History & Health Assessment

Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_  
 School: \_\_\_\_\_ Sex: F \_\_\_\_\_ M \_\_\_\_\_ Sports: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Personal Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
 In Case of an Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Home Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Other: \_\_\_\_\_

**Attention parent or guardian and athlete: answers to the following questions are very important!  
 Please take the time to answer each question to the best of your knowledge.**

### General Medical History:

- |  | Yes | No  |
|--|-----|-----|
| 1. Do you have asthma? .....   | ___ | ___ |
| 2. Do you have diabetes? .....   | ___ | ___ |
| 3. Do you have high blood pressure? .....  | ___ | ___ |
| 4. Do you have seizures? .....   | ___ | ___ |
| 5. Do you have sickle cell trait? .....  | ___ | ___ |
| 6. Do you have any other major medical problems?   | ___ | ___ |
| 7. Have you ever been hospitalized or had surgery?   | ___ | ___ |
| 8. Do you cough, wheeze or have trouble breathing<br>with exercise? .....  | ___ | ___ |
| 9. Do you use an inhaler? .....  | ___ | ___ |
| 10. Do you have a single organ, testicle or kidney?  | ___ | ___ |
| 11. Are you currently taking any medicines on<br>a regular basis (prescription or over-the-counter)?                       | ___ | ___ |
| 12. Have you ever taken supplements or vitamins<br>to help with weight loss, weight gain or improve<br>performance? .....  | ___ | ___ |
| 13. Do you have any allergies (seasonal, insects,<br>Food, latex or medicines)? .....                                      | ___ | ___ |
| 14. Have you ever had a rash or hives develop<br>during or after exercise? .....   | ___ | ___ |
| 15. Do you have a skin problem other than acne? ....   | ___ | ___ |
| 16. Have you ever had a head injury, been knocked<br>out, lost your memory, had your "bell rung" or<br>a concussion? ..... | ___ | ___ |
| 17. Have you ever had numbness or tingling in your<br>arms, hands, legs, or feet? .....                                    | ___ | ___ |
| 18. Have you had a stinger, burner or pinched nerve?   | ___ | ___ |
| 19. Have you ever become ill from exercising in<br>the heat? .....   | ___ | ___ |
| 20. Have you had mononucleosis or any significant<br>illness in the last 60 days? .....                                    | ___ | ___ |
| 21. Do you have trouble with your eyes/wear glasses?   | ___ | ___ |
| 22. Do you have trouble with your hearing/wear<br>hearing aids? .....  | ___ | ___ |

### General Medical History:

- |  | Yes | No  |
|--|-----|-----|
| 23. Do you want to weigh more/less than you do now?  | ___ | ___ |
| 24. Do you lose weight regularly to meet weight<br>requirements for your sport or other reasons? ..... | ___ | ___ |
| 25. Do you feel stressed out, tired or depressed? .....  | ___ | ___ |
| 26. Are there any issues that you would like to discuss<br>with the doctor? .....                      | ___ | ___ |
| 27. Are your immunizations up to date? .....   | ___ | ___ |

### Females Only

- |   |     |     |
|---|-----|-----|
| 28. Are your periods regular (every month)? ..... | ___ | ___ |
| 29. Are your periods heavy? .....                 | ___ | ___ |

### Cardiac History

- |  |     |     |
|--|-----|-----|
| 1. Have you ever passed out during or after exercise?  | ___ | ___ |
| 2. Have you ever been dizzy during or after exercise?  | ___ | ___ |
| 3. Have you ever had chest pains or chest pressure<br>during or after exercise? .....          | ___ | ___ |
| 4. Do you tire easily or more quickly than your<br>friends during exercise? .....              | ___ | ___ |
| 5. Have you ever had racing of your heart or skipped<br>heartbeats? .....                      | ___ | ___ |
| 6. Have you been told you had a heart murmur?  | ___ | ___ |
| 7. Have you ever been told that you had an enlarged<br>or weak heart? .....                    | ___ | ___ |
| 8. Has any member of your family:<br>Died of heart problems or sudden death before age 50? ... | ___ | ___ |
| Been told they had a serious heart problem before age 50?                                      | ___ | ___ |
| Been told they had Marfan Syndrome?.....   | ___ | ___ |
| 9. Has a physician ever restricted your participation in<br>sports? .....                      | ___ | ___ |

### Orthopedic History

- |  |     |     |
|--|-----|-----|
| 1. Have you ever broken or fractured any bones? .....  | ___ | ___ |
| 2. Have you ever dislocated any joint? .....   | ___ | ___ |
| 3. List any other problems with neck, spine, back, shoulders, elbows,<br>wrists, hands, fingers, hips, knees, ankles, feet or toes |     |     |

*Explain "Yes" Answers on another page (put date of injury if known)*

### 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 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 in these events, including medical or surgical treatment that is recommended by a medical doctor. I grant permission to nurses, trainers, coaches, doctors or those under their direction who are part of the athletic injury prevention or 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. My signature indicates that to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete \_\_\_\_\_ Date \_\_\_\_\_

Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

# SOUTH CAROLINA INDEPENDENT SCHOOL ASSOCIATION

Please Print

## Medical Examination Form

\_\_\_\_\_  
 Last Name                      First Name                      Middle Initial                      Date of Birth

Gender: \_\_\_ M \_\_\_ F                      Age: \_\_\_\_\_                      Grade: \_\_\_\_\_

**PHYSICAL EXAM** - To Be Completed By Physician or trained medical personnel under the supervision of a physician.

Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_

	Normal	Abnormal Findings	Initials
1. Eyes (vision)			
2. Ears, Nose, Throat			
3. Mouth & Teeth			
4. Neck			
5. Cardiovascular			
6. Abdomen			
7. Chest & Lungs			
8. Skin			
9. Genitalia-Hernia (male)			
10. Musculoskeletal: ROM, strength, etc.			
• Neck			
• Spine			
• Shoulders			
• Arms/hands			
• Hips			
• Thighs			
• Knees			
• Ankles			
11. Neuromuscular			

\_\_\_\_\_ **Cleared without restriction**

\_\_\_\_\_ **Cleared, with recommendations for further evaluation or treatment for:** \_\_\_\_\_

\_\_\_\_\_ **Not Cleared:**    \_\_\_ **All Sports**    \_\_\_ **Certain Sports:** \_\_\_\_\_

I certify that I have examined this athlete on this date and found him/her medically qualified to participate in sports. I also certify that I am a licensed physician or work directly with a licensed physician.

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Address: \_\_\_\_\_