ATHLETIC PREPARTICIPATION HEALTH SCREENING Date________________

Name____Date of Birth________________

Phone____Sex____________Sport____________________________

Address/City/State/Zip____

Emergency Contact Name____

Relationship________________________________Phone____

Name of Family Physician____

MEDICAL HISTORY

Place a check next to any condition that you have/have had within the past FIVE years.

____ Tested Positive for **COVID-19**?

If Yes, date of positive test? ____

____Concussion

If Yes, how many?______________________ When was the most recent?________________________

____Allergies (If Yes, specify)____

____Asthma____

____Diabetes____

RECORD OF SYMPTOMS & CONDITIONS:

Place a check next to any condition that you have/have had

____Difficulty hearing
____Nose Bleeds
____Headaches
____Convulsions
____Hernia
____Kidney/Bladder
____Blackouts
____Menstrual cramps
____Shortness of breath
____Tonsillitis
____Epilepsy
____Surgery
____Chest pain
____High blood pressure
____Fainting spells
____Appendicitis
____Heart Disease

If you have checked any of the above, please explain in detail:

____
____
____

VISION: Place a check next to the following that apply to you

____Use eye glasses ____Use contact lenses

If yes, what do you use while competing? ____

MEDICATION

Are you currently taking any medications at this time? (YES) (NO)
If yes, please list all drugs or medications and daily usage/dosage.

____

ORTHOPEDIC SCREENING

Check if you have ever injured any of the following and if you had surgery for the injury:

____Face or Head
____Neck or Back
____Chest or Abdomen
____Shoulder
____Arm
____Wrist or Hand
____Leg
____Knee
____Ankle or Foot

If yes to any of the above, please give brief explanation and date of onset.

____
____

-------------------------THE FOLLOWING WILL BE COMPLETED BY THE PHYSICIAN------------------

HEALTH SCREENING

___________Left Vision, ___________Right Vision

___________Height
___________Weight
___________Blood Pressure
___________Pulse
___________Respiratory
___________Cardiovascular
___________Ears
___________Nose
___________Throat
___________Hernia

Shoulder:
___________ROM____
___________Strength____
___________Ligament Laxity____

Knee:
___________ROM____
___________Strength____
___________Ligament Laxity____

Ankle:
___________ROM____
___________Strength____
___________Ligament Laxity____

Other:
___________ROM____
___________Strength____
___________Ligament Laxity____

COMMENTS AND RECOMMENDATIONS

I hereby certify that ______________________________ was examined by me on ____________________. At that time, no physical condition was detected which would reasonably be anticipated to render this athlete physically unfit to engage in any sport except ____________________ (if none, state so.)

Signature of examining physician (MUST BE MD)____