

# CLOVIS USD SPORTS PRE-PARTICIPATION SCREENING FORM

This form MUST be completed for every sports participant with parent/guardian & athlete signatures

Student's Name \_\_\_\_\_ Sex M F Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Student ID # \_\_\_\_\_

Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

In case of emergency, contact:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_

Explain "YES" answers below. Circle questions you do not know the answers to.

- |   | YES                      | NO                       |  |
|---|--------------------------|--------------------------|--|
| 1. Do you have any major health conditions?   | <input type="checkbox"/> | <input type="checkbox"/> | 12. Do you have Diabetes <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>  |
| 2. Have you had a medical illness or injury since your last check up or sports physical?  | <input type="checkbox"/> | <input type="checkbox"/> | If so, do you take insulin? <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>   |
| 3. Have you ever been hospitalized overnight?   | <input type="checkbox"/> | <input type="checkbox"/> | 13. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example: knee braces, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>            |
| 4. Have you ever had surgery?   | <input type="checkbox"/> | <input type="checkbox"/> | 14. Have you ever had a sprain, strain or swelling after injury, or any other problem with pain or swelling in muscles, tendons, bones or joints? <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/><br>If yes, check appropriate box, indicate R for right and L for left, and explain below: |
| 5. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills?<br>a. Have you ever taken any supplements, steroids, or vitamins, protein, creatine to help you gain or lose weight or improve your performance? | <input type="checkbox"/> | <input type="checkbox"/> |  |
| 6. Do you have any allergies (for example: medication, food, stinging insects or pollen)?   | <input type="checkbox"/> | <input type="checkbox"/> | Head <input type="checkbox"/> Elbow <input type="checkbox"/> Hip <input type="checkbox"/>  |
| 7. Have you ever passed out during or after exercise?<br>a. Have you ever been dizzy during or after exercise?<br>b. Have you ever had chest pain during or after exercise?   | <input type="checkbox"/> | <input type="checkbox"/> | Neck <input type="checkbox"/> Forearm <input type="checkbox"/> Thigh <input type="checkbox"/>  |
|   | <input type="checkbox"/> | <input type="checkbox"/> | Back <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/>   |
| c. Do you get tired more quickly than your friends do during exercise?  | <input type="checkbox"/> | <input type="checkbox"/> | Chest <input type="checkbox"/> Hand <input type="checkbox"/> Shin <input type="checkbox"/>   |
| d. Have you ever had racing of your heart or skipped heartbeats?  | <input type="checkbox"/> | <input type="checkbox"/> | Shoulder <input type="checkbox"/> Finger <input type="checkbox"/> Calf <input type="checkbox"/>  |
| e. Have you had high blood pressure or high cholesterol?  | <input type="checkbox"/> | <input type="checkbox"/> | Arm <input type="checkbox"/> Ankle <input type="checkbox"/> Foot <input type="checkbox"/>  |
| f. Have you ever been told you have a heart murmur?   | <input type="checkbox"/> | <input type="checkbox"/> | 15. Have you had any problems with your eyes or vision, wear glasses, contact lenses or protective eyewear? <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>   |
| g. Has any family member or relative died of heart problems or of sudden death before age 50?   | <input type="checkbox"/> | <input type="checkbox"/> | 16. Explain "YES" answers here: _____<br>_____<br>_____<br>_____<br>_____  |
| h. Have you had a severe viral infection (for example: infection in the heart or mononucleosis) within the last six months?   | <input type="checkbox"/> | <input type="checkbox"/> |  |
| i. Has a physician ever denied or restricted your participation in sports for any heart problems?   | <input type="checkbox"/> | <input type="checkbox"/> |  |
| 8. Do you have any current skin problems (for example: itching, rashes, acne, warts, fungus or blisters)?   | <input type="checkbox"/> | <input type="checkbox"/> |  |
| 9. Have you ever had a head injury or concussion?   | <input type="checkbox"/> | <input type="checkbox"/> |  |
| a. Have you ever been knocked out, become unconscious or lost your memory?  | <input type="checkbox"/> | <input type="checkbox"/> | 17. <b>For females</b> , age at first period _____<br>Are periods regular? <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>  |
| b. Have you ever had a seizure?   | <input type="checkbox"/> | <input type="checkbox"/> | 18. Date of Tdap _____<br><br>I have at least \$1500 in accidental medical coverage through _____ Company, policy # _____. Is this school coverage? Y / N<br>Tackle Football? Y / N 24 hour Coverage? Y / N  |
| c. Do you have frequent or severe headaches?  | <input type="checkbox"/> | <input type="checkbox"/> |  |
| d. Have you ever had numbness or tingling in your arms, hands, legs or feet?  | <input type="checkbox"/> | <input type="checkbox"/> |  |
| e. Have you ever had a stinger, burner or pinched nerve?  | <input type="checkbox"/> | <input type="checkbox"/> |  |
| 10. Have you ever become ill from exercising in the heat?   | <input type="checkbox"/> | <input type="checkbox"/> |  |
| 11. Do you cough, wheeze or have trouble breathing during or after activity?  | <input type="checkbox"/> | <input type="checkbox"/> | <p><b>I hereby state that to the best of my knowledge, my answers to all the above questions are correct and complete and I take full responsibility for any incorrect answers.</b></p> <p>Signature of Athlete _____</p> <p>Signature of Parent/Guardian _____</p> <p>Date _____</p>                              |
| a. Do you have asthma or use an inhaler?  | <input type="checkbox"/> | <input type="checkbox"/> |  |
| b. Do you have seasonal allergies that require medical treatment?   | <input type="checkbox"/> | <input type="checkbox"/> |  |

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Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BMI: \_\_\_\_\_ Pulse: \_\_\_\_\_ BP: \_\_\_\_/\_\_\_\_ Hgb: \_\_\_\_\_

Vision: Grossly Intact \_\_\_\_\_ Corrected: Y or N Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

Physical Screening	Normal Findings	X	Abnormal Findings	No Exam
Appearance	WDWN			
Eyes/Ears/Nose/Throat	WNL			
Lymph Nodes	WNL			
Hearing	Grossly Intact			
Heart	RRR, No Significant Murmur			
Pulses	WNL			
Lungs	Clear/equal			
Abdomen	Soft, No HSMT			
Skin	Warm/Dry/Intact			
Neck	FROM			
Back	No Scoliosis			
Shoulder/Arm/Elbow	FROM, = strength			
Forearm/Wrist/Hand	FROM, = grip/strength			
Hip/Thigh/Knee	FROM			
Leg/Ankle/Foot	FROM			
Hernia/Squat/Duck Walk	WNL			
Immunizations given				

## CLEARANCE

- Cleared
- NOT** Cleared until completed evaluation/rehabilitation for: \_\_\_\_\_

- Not cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_
- Recommendations: \_\_\_\_\_

Name of Health Care Provider (print/type/stamp): \_\_\_\_\_ Date of exam: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of Health Care Provider: \_\_\_\_\_ Date of signature: \_\_\_\_\_

This form was developed based upon guidelines from the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Sports Medicine, the American Medical Society for Sports Medicine, the American Orthopedic Society for Sports Medicine and the American Academy of Sports Medicine, 2009.