Annunciation Catholic School
Sports Pre-Participation Examination

Name: _____ Birthdate: _____/_____/_____

Address: _____ Phone: (_____)_____

Athlete and Parent/Guardian: Please review all questions and answer them to the best of your ability.
Physician: Please review with the athlete details of any positive answers.

YES NO Don't Know 1. Has anyone in the athlete's family died suddenly before the age of 50 years?

YES NO Don't Know 2. Has the athlete ever passed out during exercise or stopped exercising because of dizziness or chest pain?

YES NO Don't Know 3. Does the athlete have asthma (wheezing), hay fever, or coughing spells during or after exercise?

YES NO Don't Know 4. Has the athlete ever broken a bone, had to wear a cast, or had an injury to any joint?

YES NO Don't Know 5. Does the athlete have a history of a concussion (getting knocked out) or seizures?

YES NO Don't Know 6. Has the athlete ever suffered a heat-related illness (heat stroke)?

YES NO Don't Know 7. Does the athlete have a chronic illness or see a physician regularly for any particular problem?

YES NO Don't Know 8. Does the athlete take any prescribed medicine, herbs, or nutritional supplements?

YES NO Don't Know 9. Is the athlete allergic to any medications or bee stings?

YES NO Don't Know 10. Does the athlete have only one of any paired organ (eyes, ears, kidneys, testicles, ovaries, etc.)?

YES NO Don't Know 11. Has the athlete ever had prior limitation from sports participation?

YES NO Don't Know 12. Has the athlete had any episodes of shortness of breath, palpitations, history of rheumatic fever or unusual fatigability?

YES NO Don't Know 13. Has the athlete ever been diagnosed with a heart murmur or heart condition or hypertension?

YES NO Don't Know 14. Is there a history or young people in the athlete's family who have had congenital or other heart disease: cardiomyopathy, abnormal heart rhythms, long QT or Marfan's syndrome? (You may write "I don't understand these terms" and initial this term, if appropriate.)

YES NO Don't Know 15. Has the athlete ever been hospitalized overnight or had surgery?

YES NO Don't Know 16. Does the athlete lose weight regularly to meet requirements for your sport?

YES NO Don't Know 17. Does the athlete have anything he or she wants to discuss with the physician?

YES NO Don't Know 18. Does the athlete cough, wheeze, or have trouble breathing during or after activity?

YES NO Don't Know 19. Does the athlete have asthma?

Parent/Guardian's Statement:

I have reviewed and answered the questions above to the best of my ability. I and my child understand and accept that there are risks of serious injury and death in any sport, including the one(s) in which my child has chosen to participate. I hereby give my permission for my child to participate in sports / activities. I hereby authorize emergency medical treatment and/or transportation to a medical facility for any injury or illness deemed urgently necessary by a licensed athletic trainer, coach, or medical practitioner. I understand that this sports pre-participation physical examination is not designed nor intended to substitute for any recommended regular comprehensive health assessment. I hereby authorize release of these examination results to my child's school.

Parent/Guardian Signed: _____ Date: _____

As per ORS 336.479, Section 1 (5) "Any physical examination required by this section shall be conducted by a (a) physician possessing an unrestricted license to practice medicine; (b) licensed naturopathic physician; (c) licensed physician assistant; (d) certified nurse practitioner; or a (e) licensed chiropractic physician who has clinical training and experience in detecting cardiopulmonary diseases and defects."

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NAME:_____ BIRTHDATE:_____/_____/_____

Height:_____ Weight:_____ % Body Fat(optional): _____ Pulse: _____ BP:____/____ (___/___, ____/____)

Vision: R 20/_____ L 20/_____ Corrected: Y N Pupils: Equal_____ Unequal_____ Rhythm: Regular_____ Irregular_____

MEDICAL	NORMAL	ABNORMAL FINDING	INITIALS*
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Pericardial activity			
Heart:1st and 2nd heart sounds			
Murmurs			
Pulses			
brachial/femoral Lungs			
Abdomen			
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: _____

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