PROVO HIGH SCHOOL

SPORTS MEDICINE PRE-PARTICIPATION EXAM

FORM VALID FROM
MARCH 1st – End of School Year
(must be renewed each school year)

ATHLETE INFORMATION Must be filled out by the ATHLETE or PARENT/GUARDIAN prior to the physical examination.

Name: _____ Birth Date (MM/DD/YYYY): _____/_____/_____ Grade: 8 | 9 | 10 | 11 | 12 Gender: M | F

Sport(s): _____
PLEASE LIST ALL SPORTS FOR WHICH YOU WILL TRY OUT FOR THIS YEAR.

PHYSICIAN SECTION Must be filled out by the PHYSICIAN prior to any try-out, practice, or athletic contest.

Height: _____ Weight: _____ Pulse: _____ BP: _____ BF%(opt): _____

VISION | Left: _____ /20 Right: _____ /20 Corrected? ☐ Yes ☐ No Pupils? ☐ Equal ☐ Unequal

MEDICAL	NORMAL	ABNORMAL (include findings)
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Skin		
Genitalia (male)		
Menstrual Period (female)		

MUSCULOSKELETAL	NORMAL	ABNORMAL (include findings)
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		

ADDITIONAL COMMENTS _____

_____

_____

_____

ATHLETIC PARTICIPATION RECOMMENDATIONS

- ☐ **FULL** & Unlimited Participation
- ☐ **LIMITED** Participation - May NOT participate in the following: _____
- ☐ **CLEARED PENDING** Documented follow-up of _____
- ☐ **NOT CLEARED** for Athletic Participation

Date of EXAM (MM/DD/YYYY): _____/_____/_____

_____
Physician Name (please print)

_____
Physician Signature

DOCTOR'S OFFICE ADDRESS INFORMATION

Phone (_____) _____ - _____

EMERGENCY
CONSENT FOR TREATMENT

BE IT KNOWN that in the event I cannot be reached, I, the undersigned parent/guardian of the student above named, do hereby give and grant unto any medical doctor or hospital my consent and authorization to render such aide, treatment or care to said student as, in the judgment of said doctor or hospital may be required, on an emergency basis, in the event said student/athlete should be injured or stricken ill while participation in an interscholastic activity sponsored by the above activity sponsored by the above school.

IT IS HEREBY understood that the consent and authorization hereby given and granted are continuing and are intended by me to extend throughout the current school year.

IT IS FURTHER understood that any expenses incurred will be paid for by insurance or the parent/guardian of the student. Payment of the expenses is not the school's responsibility.

_____
Parent/Guardian NAME (please print)

_____
Parent/Guardian SIGNATURE

_____/_____/_____
Date (MM/DD/YYYY)

ATHLETE MEDICAL HISTORY

Have you had a medical illness or injury since your last check up or sports physical? _____ Yes No

Do you have an ongoing or chronic illness? _____ Yes No

Are you under doctor's care right now? _____ Yes No

Have you been hospitalized overnight in the past year? _____ Yes No

Have you ever had surgery? _____ Yes No

Have you ever passed out during or after exercise? _____ Yes No

Do you get tired more quickly than your friends do during exercise? _____ Yes No

Have you ever had racing of your heart or skipped heartbeats? _____ Yes No

Have you ever had chest pain during or after exercise? _____ Yes No

Have you had high blood pressure or high cholesterol? _____ Yes No

Have you ever been told you have a heart murmur? _____ Yes No

Has any family member or relative died of heart problems or sudden unexpected death before age 50? _____ Yes No

Has any family member been diagnosed with enlarged heart, QT Syndrome, or other ion channelpathy, Marfan's Syndrome, or abnormal heart rhythm? _____ Yes No

Have you ever been diagnosed with a severe viral infection (for example, myocarditis or mononucleosis)? _____ Yes No

Has a physician ever denied or restricted your participation in sports for any reason? _____ Yes No

Do you have frequent or severe headaches? _____ Yes No

Have you ever had numbness or tingling in your arms, hands, legs, or feet? _____ Yes No

Have you ever had a stinger, burner, or pinched nerve? _____ Yes No

Have you ever had a head injury or concussion? _____ Yes No

Have you ever been knocked out, become unconscious, or lost your memory? If yes, how many times? _____ Last occurrence: _____ Please explain: _____ Yes No

Have you ever had a seizure? _____ Yes No

Are you missing any paired organ? _____ Yes No

Are you currently taking any prescription or non-prescription medication or pills or using an inhaler? _____ Yes No

Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? _____ Yes No

Do you have any allergies? (pollen, medicine, food, insects) _____ Yes No

Have you ever been dizzy during or after exercise? _____ Yes No

Do you have any current skin problems? (itching, rashes, acne, warts, fungus) ___ Yes No

Have you ever had a rash or hives develop during or after exercise? _____ Yes No

Have you ever become ill from exercising in the heat? _____ Yes No

Have you had any problems with your eyes or vision? _____ Yes No

Have you ever gotten unexpectedly short of breath with exercise? _____ Yes No

Do you have asthma? _____ Yes No

Do you use any special protective or corrective equipment or devises that aren't usually used for your sort or position? (knee brace, orthotics, hearing aid) _____ Yes No

Do you want to weigh more or less than you do now? _____ Yes No

Do you lose weight regularly to meet weight requirements for your sport? Yes No

Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease? _____ Yes No

Have you had any problems with pain, swelling, fracture, sprain, strain, or dislocation in any joint? If yes, check the appropriate box and explain below: Yes No

- ☐ Head _____
- ☐ Shoulder _____
- ☐ Finger _____
- ☐ Shin/Calf _____
- ☐ Hip _____
- ☐ Neck _____
- ☐ Arm _____
- ☐ Wrist _____
- ☐ Thigh _____
- ☐ Ankle _____
- ☐ Back _____
- ☐ Elbow _____
- ☐ Hand _____
- ☐ Knee _____
- ☐ Foot _____

I hereby state that to the best of my knowledge my answers to the Medical History are complete and correct.

_____

Athlete SIGNATURE