FirstCare Family Doctors
A MANA Clinic

# Pre-Participation Sports Screening

**This form must be completed, signed by a parent/legal guardian and returned at the time of the pre-participation sports screening. The exam will not be performed without this completed form.**

Sports Screening Disclaimer:

****IMPORTANT-PLEASE READ**** The AAA (Arkansas Activities Association) requires that all student athletes complete a pre-participation physical exam each year. First Care Family Doctors South offers pre-participation sports screenings that meet the annual requirements of the AAA but is not meant to take the place of your annual exam with your primary care physician or pediatrician. This screening will not address immunizations, blood work or evaluate other medical conditions that your primary care physician may perform on an annual exam.

Pre-participation physical exams cannot guarantee or accurately predict that your child is risk free. It is well known and understood that certain sports can produce injuries and that some heart abnormalities may be present even with "normal" results from a routine screening exam.

Therefore, normal results from routine pre-participation sports screening should not be interpreted as indicating that he/she is free from risk or that all potential cardiac anomalies have been ruled out.

☐ I have read and understand the disclaimer information presented above.

_____ _____
Parent/Guardian signature Parent/Guardian printed name

_____ _____
Name of athlete Date of birth

_____ _____
School Date signed

**Parents: Please complete this page and the medical history questionnaire on other side.**

**The exam will not be given if this form is not completed.**

**PARENTS- PLEASE COMPLETE THE TOP HALF OF THIS PAGE- STOP AT THE PHYSICAL EXAM SECTION**

**Name_____ School_____**

**Date of Birth_____ Sport_____**

**History- to be completed by parent/guardian**

| | | |
|---|---|---|
| **1. Played previous sports** | **Yes** | **No** |
| **2. Previous fracture or sprain** | **Yes** | **No** |
| **3. Neck or back injury** | **Yes** | **No** |
| **4. Concussion** | **Yes** | **No** |
| **5. Asthma or exercise induced bronchospasm** | **Yes** | **No** |
| **6. Excessive shortness of breath of fatigue associated with exercise** | **Yes** | **No** |
| **7. Episode of passing out or nearly passing out** | **Yes** | **No** |
| **8. Heat related illness** | **Yes** | **No** |
| **9. Bleeding disorder** | **Yes** | **No** |
| **10. Loss of paired organ _____** | **Yes** | **No** |

**Family History of the following:**

| | | | |
|---|---|---|---|
| **1. Disability from heart disease in a close relative younger than 50 years** | **Yes** | **No** | **Unknown** |
| **2. Premature death (sudden and expected, or otherwise) before 50 years of age due to heart disease** | **Yes** | **No** | **Unknown** |
| **3. Specific knowledge of certain cardiac conditions in family members: Hypertrophic or dilated cardiomyopathy, long QT syndrome, Marfan Syndrome or arrhythmias** | **Yes** | **No** | **Unknown** |

**List current medications: _____**

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**PHYSICAL EXAM**

(To be completed by healthcare provider only)

Weight_____ Height_____ BP_____ Pulse_____

HEENT WNL ABN:_____

Neck WNL ABN:_____

Chest WNL ABN:_____

Heart WNL ABN:_____

Lungs WNL ABN:_____

Abdomen WNL ABN:_____

Extremities WNL ABN:_____

Spine WNL ABN:_____

Hernia WNL ABN:_____

Cleared for athletic participation YES NO _____

Provider Signature _____ Date _____

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