THE SOUTH CAROLINA INDEPENDENT SCHOOL ASSOCIATION
Pre-Participation History & Health Assessment

Name _____ Date of Birth: _____ Grade: _____

School: _____ Sex: F ____ M ____ Sports: _____

Address: _____ Phone: _____

Personal Physician: _____ Phone: _____

In Case of an Emergency Contact: _____ Relationship: _____

Home Phone #: _____ Cell #: _____ Other: _____

Attention parent or guardian and athlete: answers to the following questions are very important!
Please take the time to answer each question to the best of your knowledge.

General Medical History:

	Yes	No
1. Do you have asthma?	___	___
2. Do you have diabetes?	___	___
3. Do you have high blood pressure?	___	___
4. Do you have seizures?	___	___
5. Do you have sickle cell trait?	___	___
6. Do you have any other major medical problems?	___	___
7. Have you ever been hospitalized or had surgery?	___	___
8. Do you cough, wheeze or have trouble breathing with exercise?	___	___
9. Do you use an inhaler?	___	___
10. Do you have a single organ, testicle or kidney?	___	___
11. Are you currently taking any medicines on a regular basis (prescription or over-the-counter)?	___	___
12. Have you ever taken supplements or vitamins to help with weight loss, weight gain or improve performance?	___	___
13. Do you have any allergies (seasonal, insects, Food, latex or medicines)?	___	___
14. Have you ever had a rash or hives develop during or after exercise?	___	___
15. Do you have a skin problem other than acne?	___	___
16. Have you ever had a head injury, been knocked out, lost your memory, had your "bell rung" or a concussion?	___	___
17. Have you ever had numbness or tingling in your arms, hands, legs, or feet?	___	___
18. Have you had a stinger, burner or pinched nerve?	___	___
19. Have you ever become ill from exercising in the heat?	___	___
20. Have you had mononucleosis or any significant illness in the last 60 days?	___	___
21. Do you have trouble with your eyes/wear glasses?	___	___
22. Do you have trouble with your hearing/wear hearing aids?	___	___

General Medical History:

	Yes	No
23. Do you want to weigh more/less than you do now?	___	___
24. Do you lose weight regularly to meet weight requirements for your sport or other reasons?	___	___
25. Do you feel stressed out, tired or depressed?	___	___
26. Are there any issues that you would like to discuss with the doctor?	___	___
27. Are your immunizations up to date?	___	___

Females Only

28. Are your periods regular (every month)?	___	___
29. Are your periods heavy?	___	___

Cardiac History

1. Have you ever passed out during or after exercise?	___	___
2. Have you ever been dizzy during or after exercise?	___	___
3. Have you ever had chest pains or chest pressure during or after exercise?	___	___
4. Do you tire easily or more quickly than your friends during exercise?	___	___
5. Have you ever had racing of your heart or skipped heartbeats?	___	___
6. Have you been told you had a heart murmur?	___	___
7. Have you ever been told that you had an enlarged or weak heart?	___	___
8. Has any member of your family:		
Died of heart problems or sudden death before age 50?	___	___
Been told they had a serious heart problem before age 50?	___	___
Been told they had Marfan Syndrome?	___	___
9. Has a physician ever restricted your participation in sports?	___	___

Orthopedic History

1. Have you ever broken or fractured any bones?	___	___
2. Have you ever dislocated any joint?	___	___
3. List any other problems with neck, spine, back, shoulders, elbows, wrists, hands, fingers, hips, knees, ankles, feet or toes		

Explain "Yes" Answers on another page (put date of injury if known)

Parent's Permission & Acknowledgement of Risk for Son or Daughter to Participate in Athletics

As the parent or legal guardian of the above named student athlete, I give my permission for his/her participation in athletic events and the physical evaluation for that participation. I understand that this is simply a screening evaluation and not a substitute for regular health care. I also grant permission for treatment deemed necessary for a condition arising during participation in these events, including medical or surgical treatment that is recommended by a medical doctor. I grant permission to nurses, trainers, coaches, doctors or those under their direction who are part of the athletic injury prevention or treatment, to have access to necessary medical information. I know that the risk of injury to my child/ward comes with participation in sports and during travel to and from play and practice. My signature indicates that to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Date _____

Signature of parent/guardian _____ Date _____

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Please Print

Medical Examination Form

Last Name _____ First Name _____ Middle Initial _____ Date of Birth _____

Gender: ___ M ___ F Age: _____ Grade: _____

PHYSICAL EXAM - To Be Completed By Physician or trained medical personnel under the supervision of a physician.

Height _____ Weight _____ Pulse _____ Blood Pressure _____

	Normal	Abnormal Findings	Initials
1. Eyes (vision)			
2. Ears, Nose, Throat			
3. Mouth & Teeth			
4. Neck / Lymph Nodes			
5. Cardiovascular			
6. Abdomen			
7. Chest & Lungs			
8. Skin			
9. Genitalia-Hernia (male)			
10. Heart (squatting to standing & supine)			
Musculoskeletal: ROM, strength, etc.			
• Neck			
• Spine/Back			
• Shoulders/Arm			
• Elbow/Forearm			
• Wrist/Hand			
• Hip/Thighs			
• Knees			
• Leg/Ankles			

____ Cleared without restriction

____ Cleared, with recommendations for further evaluation or treatment for: _____

_____

____ Not Cleared: ___ All Sports ____ Certain Sports: _____

I certify that I have examined this athlete on this date and found him/her medically qualified to participate in sports. I also certify that I am a licensed physician or work directly with a licensed physician.

Physician's Signature: _____ Date: _____

Physician's Address: _____