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 #'s: (H)_____ (W) _____ (C) _____

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

	YES	NO
1. Do you have any major health conditions?	☐	☐
2. Have you had a medical illness or injury since your last checkup or sports physical?	☐	☐
3. Have you even been hospitalized overnight?	☐	☐
4. Have you ever had surgery?	☐	☐
5. Are you missing an organ or body part?	☐	☐
6. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills?	☐	☐
7. Do you have any allergies to medication, food, stinging insects, or pollen?	☐	☐
8. Have you ever passed out or nearly passed out during or after exercise?	☐	☐
9. Have you ever been dizzy during or after exercise?	☐	☐
10. Do you get tired more quickly than your friends do during exercise?	☐	☐
11. Have you ever had racing of your heart or skipped heartbeats?	☐	☐
12. Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
13. Have you had a severe viral infection such as infection of the heart or mononucleosis within the last six months?	☐	☐
14. Has a **doctor** ever told you that you have any heart problems? If so, check all that apply: ☐ Heart murmur ☐ Heart infection ☐ High cholesterol ☐ High blood pressure ☐ Kawasaki Disease ☐ Other:_____	☐	☐
15. Has a doctor ever ordered a test for your heart, such as ECG/EKG (Echocardiogram)?	☐	☐
16. Do you have any current skin problems such as itching, rashes, acne, warts, fungus, or blisters?	☐	☐
17. Have you ever had a head injury or concussion?	☐	☐
18. Have you ever been knocked out, become unconscious or lost your memory?	☐	☐
19. Have you ever had a seizure?	☐	☐
20. Do you have frequent or severe headaches?	☐	☐
21. Have you ever had numbness or tingling in your arms, hands, legs, or feet?	☐	☐

	YES	NO
22. Have you ever had a stinger, burner, or pinched nerve?	☐	☐
23. Have you ever become ill from exercising in the heat?	☐	☐
24. Do you cough, wheeze, or have trouble breathing during or after activity?	☐	☐
25. Do you have asthma or use an inhaler?	☐	☐
If "Yes", Do you carry your inhaler while you are playing sports?	☐	☐
26. Do you have diabetes?	☐	☐
If "Yes", do you take insulin?	☐	☐
27. Do you use any protective or corrective equipment or devices that aren't usually used for your sport or position, such as knee braces, special neck roll, foot orthotics, retainer on your teeth, or hearing aid?	☐	☐
28. Have you ever had a sprain, strain, or swelling after injury, or any problem with pain or swelling in muscles, tendons, bones, or joints? If "Yes", which locations: _____	☐	☐
29. Have you had any problems with your eyes or vision, wear glasses, contact lenses, or protective eyewear?	☐	☐
30. **For females:** Age at first period: _____ Are periods regular?	☐	☐
31. Date of last tetanus shot: _____ Tdap date: _____		

Explain "YES" answers here: _____

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.

Signature of Athlete _____ **Signature of Parent/Guardian** _____ **Date** _____