

# CLOVIS USD SPORTS PRE-PARTICIPATION SCREENING FORM

This form MUST be completed for every sports participant with parent & athlete signature

Student's Name \_\_\_\_\_ Sex M or F Date of Birth \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BMI: \_\_\_\_\_ Pulse: \_\_\_\_\_ BP: \_\_\_\_/\_\_\_\_

Vision: Grossly Intact \_\_\_\_\_ Corrected: Y or N Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

Physical Screening	Normal Findings	X	Abnormal Findings	No Exam
Appearance	WDWN			
Eyes/Ears/Nose/Throat	WNL			
Lymph Nodes	WNL			
Hearing	Grossly Intact			
Heart	RRR, No Significant Murmur			
Pulses	WNL			
Lungs	Clear/equal			
Abdomen	Soft, No HSMT			
Skin	Warm/Dry/Intact			
Neck	FROM			
Back	No Scoliosis			
Shoulder/Arm/Elbow	FROM, = strength			
Forearm/Wrist/Hand	FROM, = grip/strength			
Hip/Thigh/Knee	FROM			
Leg/Ankle/Foot	FROM			
Hernia/Squat/Duck Walk	WNL			
Immunizations given				

## CLEARANCE

- Cleared
- NOT** Cleared until completed evaluation/rehabilitation for: \_\_\_\_\_

- Not cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_
- Recommendations: \_\_\_\_\_

Name of Health Care Provider (print/type/stamp): \_\_\_\_\_ Date of exam: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of Health Care Provider: \_\_\_\_\_ Date of signature: \_\_\_\_\_

This form was developed based upon guidelines from the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Sports Medicine, the American Medical Society for Sports Medicine, the American Orthopedic Society for Sports Medicine and the American Academy of Sports Medicine, 2009.

# 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                       |   | YES                      | NO                       |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Do you have any major health conditions?  | <input type="checkbox"/> | <input type="checkbox"/> | 22. Have you ever had a stinger, burner, or pinched nerve?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you had a medical illness or injury since your last checkup or sports physical?  | <input type="checkbox"/> | <input type="checkbox"/> | 23. Have you ever become ill from exercising in the heat?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you even been hospitalized overnight?  | <input type="checkbox"/> | <input type="checkbox"/> | 24. Do you cough, wheeze, or have trouble breathing during or after activity?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had surgery?  | <input type="checkbox"/> | <input type="checkbox"/> | 25. Do you have asthma or use an inhaler?<br>If "Yes", Do you carry your inhaler while you are playing sports?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you missing an organ or body part?  | <input type="checkbox"/> | <input type="checkbox"/> | 26. Do you have diabetes?<br>If "Yes", do you take insulin?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills?   | <input type="checkbox"/> | <input type="checkbox"/> | 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have any allergies to medication, food, stinging insects, or pollen?   | <input type="checkbox"/> | <input type="checkbox"/> | 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?<br>If "Yes", which locations: _____                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever passed out or nearly passed out during or after exercise?   | <input type="checkbox"/> | <input type="checkbox"/> | 29. Have you had any problems with your eyes or vision, wear glasses, contact lenses, or protective eyewear?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever been dizzy during or after exercise?  | <input type="checkbox"/> | <input type="checkbox"/> | 30. <b>For females:</b> Age at first period: _____<br>Are periods regular?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you get tired more quickly than your friends do during exercise?  | <input type="checkbox"/> | <input type="checkbox"/> | 31. Date of last tetanus shot: _____<br>Tdap date: _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever had racing of your heart or skipped heartbeats?  | <input type="checkbox"/> | <input type="checkbox"/> | Explain "YES" answers here: _____<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____  |                          |                          |
| 12. Has any family member or relative died of heart problems or of sudden death before age 50?   | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| 13. Have you had a severe viral infection such as infection of the heart or mononucleosis within the last six months?  | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| 14. Has a <b>doctor</b> ever told you that you have any heart problems?<br>If so, check all that apply:<br><input type="checkbox"/> Heart murmur <input type="checkbox"/> Heart infection<br><input type="checkbox"/> High cholesterol <input type="checkbox"/> High blood pressure<br><input type="checkbox"/> Kawasaki Disease <input type="checkbox"/> Other: _____ | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| 15. Has a doctor ever ordered a test for your heart, such as ECG/EKG (Echocardiogram)?   | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| 16. Do you have any current skin problems such as itching, rashes, acne, warts, fungus, or blisters?   | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| 17. Have you ever had a head injury or concussion?   | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| 18. Have you ever been knocked out, become unconscious or lost your memory?  | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| 19. Have you ever had a seizure?   | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| 20. Do you have frequent or severe headaches?  | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| 21. Have you ever had numbness or tingling in your arms, hands, legs, or feet?   | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |

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 \_\_\_\_\_