PARENTS' PERMISSION FOR SON OR DAUGHTER TO PARTICIPATE IN ATHLETICS

TO: Principal or Superintendent:

As the parents or legal guardian of____________________________, I give my consent for his/her practice and play in the athletic events listed below and for the physical exam evaluation for that participation. I grant permission to nurses, trainers and coaches as well as physicians or those under their direction who are part of athletic injury prevention and treatment, to have access to necessary medical information. I grant permission for treatment deemed necessary for a condition arising during participation in these activities, including medical or emergency treatment recommended by a medical doctor. I understand that every effort will be made to contact me prior to treatment. I certify that the medical history on the preceding page is accurate to the best of my knowledge. I understand that the data acquired may be used for research purposes to improve athletic care. I give the South Carolina High School League permission to examine the school records of the above student in order to verify eligibility.

DATE___________ **SIGNED**__________________________________

(Father, mother, or Legal guardian)

PREPARTICIPATION PHYSICAL EXAM

VITAL SIGNS

R L

HT_________WT_________ (SKINFOLD _____mm) PULSES: WRIST _____ _____

VISION R 20/ L 20/ FEM _____ _____

(CORRECTED) DENTAL ___________________ HEART RATE ____________

R 20/ L 20/ BP _________________________

CK NEG RECORD ABNORMALS

PHYSICAL

APPEARANCE:

PUPILS:

EENT:

LUNGS:

HEART:

ABDOMEN:

GU:

SKIN:

LYMPH NODES:

CK NEG RECORD ABNORMALS

MUSCLSKEL **ROM INSTABIL DEFORMITY**

C SPINE:

T SPINE:

LS SPINE:

SHOULDER:

ELBOW:

WRIST:

HAND:

HIP:

KNEE:

ANKLE:

FOOT:

CLEARED (I)___ CROSS OUT SPORT NOT PERMITTED

FOOTBALL BASKETBALL BASEBALL SOFTBALL VOLLEYBALL WRESTLING FIELD HOCKEY

SOCCER CROSS COUNTRY TRACK TENNIS GOLF BOWLING CHEERLEADING SWIMMING

NEEDS FURTHER EVAL (II)____ EVALUATION BY___________________________

REHAB BY_________________________________

SECONDARY CLEARANCE (I)___________________________MD or DO Date_________

NOT CLEARED(III)___ REASON:

COLLISION__________________ CONTACT__________________ NONCONTACT_________________

STRENUOUS__________MODERATELY STRENUOUS__________NONSTRENUOUS__________

NAME OF PHYSICIAN OR FACILITY:

ADDRESS: PHONE:

SIGNATURE______________________________MD or DO Date____________

HISTORY PREPARTICIPATION PHYSICAL EVALUATION **DATE OF EXAM**___________

Name____ Sex________Age_________ Date of Birth _________________

Grade________School______________________________Sport(s)_______________________ Phone _________________

Address____

Personal Physician______________________ IN CASE OF EMERGENCY, CONTACT ______________________________

Name__________________________ Relationship__________ Phone (H)__________________ (W)__________________

Social Security #: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

FILL YES / NO BOXES **Explain "Yes" answers below.** **Circle questions you don't know the answers to completely.**

	Question	Yes	No
1.	Have you had a medical illness or injury since your last check up or sports physical?	☐	☐
	Do you have an ongoing or chronic illness?	☐	☐
2.	Have you ever been hospitalized overnight?	☐	☐
3.	Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?	☐	☐
	Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	☐	☐
4.	Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	☐	☐
	Have you ever had a rash or hives develop during or after exercise?	☐	☐
5.	Have you ever passed out during or after exercise?	☐	☐
	Have you ever been dizzy during or after exercise?	☐	☐
	Have you ever had chest pain, chest discomfort, or unexplained shortness of breath during or after exercise?	☐	☐
	Do you get tired more quickly than your friends do during exercise?	☐	☐
	Have you ever had racing of your heart or skipped heartbeats?	☐	☐
	Have you had high blood pressure or high cholesterol?	☐	☐
	Have you ever been told you have a heart murmur?	☐	☐
	Has any family member or relative died of heart problems or sudden death before age 50?	☐	☐
	Has any relative younger than 50 ever had disability from heart or cardiovascular disease ?	☐	☐
	Do you have, or do you know any family member or relative with ANY heart condition (Marfans, cardiomyopathy, or arrhythmia – irregular heartbeat)	☐	☐
	Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	☐	☐
	Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐
6.	Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	☐	☐
7.	Have you ever had a head injury or concussion?	☐	☐
	Have you ever been knocked out, become unconscious, or lost your memory?	☐	☐
	Have you ever had a seizure?	☐	☐
	Do you have frequent or severe headaches?	☐	☐
	Have you ever had numbness or tingling in your arms, hands, legs, or feet?	☐	☐
	Have you ever had a stinger, burner, or pinched nerve?	☐	☐
8.	Have you ever become ill from exercising in the heat?	☐	☐
9.	Do you cough, wheeze, or have trouble breathing during or after activity?	☐	☐
	Do you have asthma?	☐	☐
	Do you have seasonal allergies that require medical treatment?	☐	☐

Explain any "Yes" answers here: ______________________________

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	Question	Yes	No
10.	Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	☐	☐
11.	Have you had any problems with your eyes or vision?	☐	☐
	Do you wear glasses, contacts, or protective eyeware?	☐	☐
12.	Have you ever had a sprain, strain, or swelling after injury?	☐	☐
	Have you broken or fractured any bones or dislocated any joints?	☐	☐
	Have you had any other problems with pain or swelling in the muscles, tendons, bones, or joints?	☐	☐

ANSWER BELOW		For Examiner Use Only							
Please MARK & FILL appropriate box of problem areas. Explain below in the space provided what you understood your injury to be. Do not mark spaces to right of this section.		**Overuse**	**Strain**	**Sprain**	**Contusion**	**Concussion**	**Dislocated**	**Laceration**	**Fracture**
	Head								
	Neck								
	Back								
	Shoulder/Arm								
	Elbow/Forearm								
	Wrist/Hand/Finger								
	Hip/Thigh								
	Knee								
	Leg/Ankle								
	Foot/Toe								

	Question	Yes	No
13.	Do you want to weigh more or less than you do now?	☐	☐
	Do you lose weight regularly to meet weight requirements for your sport?	☐	☐
14.	Do you feel stressed out?	☐	☐

15. Record the dates of your most recent immunizations (shots) for:
    Tetanus___________________ Measles___________________
    Hepatitis B________________ Chickenpox________________

FEMALES ONLY

16. When was your first menstrual period?____________________
    When was your **most recent** menstrual period?_______________
    How much time do you usually have from the start of one period to the start of another?_____________________________
    How many periods have you had in the last year?______________
    What was the longest time between periods in the last year?______

Explain any INJURY here: ___________________________________

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