

WHSA Preparticipation Examination

To be completed by athlete or parent.

Name _____ Last _____ First _____ Middle _____ Sport/Position _____

Social Security Number _____ School Year _____

Address _____ City/State _____ Phone No. _____

Birthdate _____ Age _____ Class _____ Student ID No. _____

Parent's Name _____ Address _____

Phone No. _____ Person to contact in case of emergency? _____

Phone No. _____ Family Doctor _____ City/State _____ Phone No. _____

Past Medical History

Yes No If yes, please explain (what, where, when)

1. Presently taking medication (including birth control pills)?
2. Allergic to medicines, foods, bee stings?
3. Wears any appliances—glasses, contact lenses?
4. History of braces, chipped teeth, bridges?
5. Has ongoing medical problem?
6. Had serious or significant illness in past?
7. Any past surgical operations, accidents, non-sports or related injuries?
8. Any past injuries directly related to sports?
9. Any hospitalization not explained above?
10. Any known deformities (such as curvature of back, heart problems, one kidney, blindness in one eye, one testicle, etc.)?
11. Any serious family illness (such as diabetes, bleeding disorders, etc.)?
12. Heart

Have you ever passed out during or after exercise? _____
 Have you ever been dizzy during or after exercise? _____
 Have you ever had chest pain 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 of sudden death before age 50? _____
 Have you had a severe viral infection (for example myocarditis or mononucleosis) within the last month? _____

Yes No If yes, please explain (what, where, when)

13. Has a physician ever denied or restricted your participation in sports for any heart problems? Has anyone in your family had a heart attack before the age of 50? Head and Nerve
14. Have you ever had a head injury or concussion? Have you ever been knocked out, become unconscious, or lost your memory? 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?
15. Last tetanus shot? Last eye exam?
16. Last menstrual period (if women)

Personal Habits

1. Smoking/smokeless tobacco
2. Alcohol/non-medical drugs: marijuana, cocaine, etc
3. Steroids
4. Eating Disorders - weight loss or gain?

Review of systems (Please check if you have any problems with any of the following areas of your body)

Skin _____ Lungs _____ Shoulders, Arms, _____
 Head _____ Heart _____ Hands _____
 Eyes _____ Abdomen _____ Hips, Legs, Feet _____
 Ears _____ Back _____ Muscles—Strength _____
 Nose _____ Urination, _____ Feeling _____
 Mouth/Throat _____ Bowel Control _____ Mental, Emotional _____
 Nutrition, _____ Genital (including _____ Fatigue _____
 Weight Control _____ menstrual for women) _____ Other: What? _____
 Neck _____

I certify that the above information is correct to the best of my knowledge.

Student Signature _____

Parent/Guardian Signature _____

Both Student And Parent/Guardian Signatures Are Mandatory

Physical Examination

Height _____ Weight _____ Blood Pressure _____
 Pulse: resting _____ 15 hops _____ after 2 minutes _____
 Visual Acuity: Eyes (R) 20/ _____ w/o glasses _____ (L) 20/ _____ w/ glasses _____

Other Testing

Normal

Abnormal Findings

- 1. General
- 2. Skin
- 3. HEENT
- 4. Teeth (Dental Exam)
- 5. Neck
- 6. Lungs
- 7. Heart (Sit and Stand)
- 8. Abdomen
- 9. Genitalia
- 10. Musculoskeletal

- Neck
- Shoulder/Arm
- Elbow/Forearm
- Wrist/Hand
- Back
- Hip/Thigh
- Knee
- Shin/Calf
- Ankle/Leg
- Foot
- 11. Peripheral Pulses
- 12. Neurologic
- 13. Mental Status
- 14. Marfan Screen

Other Tests (optional)

- Auditory
- % Body Fat
- Hgb/Hct
- U/V
- Drug Screen
- S/MAC
- EKG
- Chest X-Ray
- Tanner Stage

On the basis of the examination on this day, I approve the child's participation in interscholastic sports for one year.

Yes _____ No _____ Limited _____

Additional Comments:

Examination Date _____ Physician's Signature _____

STUDENT'S NAME _____

SCHOOL NAME _____

