Buena Park High School
Pre-Participation Examination

Physical Examination:

Name of Athlete: ______________________________ Date of Birth: _____/_____/____
Status: New ______ Returning: ______ Sport: _____________________________
Height: ____________ Weight: ____________ lbs Pulse: ____________ bpm
BP: _______/_______ Eyes: R: ______/20 L: ______/20 Glasses: YES/NO
Contacts: YES/NO Pupils: Equal _____ Unequal ______

Medical Examination:

	NORMAL	ABNORMAL
APPEARANCE • Marfans Stigmata, etc		
SKIN • HSV, Lesions (MRSA, Tinea Corpis)		
EYES/EARS • Pupils equal • Hearing		
NOSE/ THROAT		
LYMPH NODES		
HEART • Murmurs • PMI		
PULSES • Simultaneous		
LUNGS		
ABDOMEN		
GENITOURINARY (Males Only)		
NEUROLOGICAL		

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Musculoskeletal Examination:

	NORMAL	ABNORMAL
HEAD		
NECK		
SPINE		
SHOULDER/ ARM		
ELBOW/ FOREARM		
WRIST/ HAND/ FINGER		
HIP		
THIGH		
KNEE		
LEG/ ANKLE		
FOOT/ TOES		
FUNCTIONAL (Duck Walk, Single Leg Hop, Squat)		

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Medical Clearance Form:

☐ Cleared for all sports without restrictions

☐ Cleared for all sports without restrictions after completing evaluation/treatment for:
____

☐ Not Cleared for athletic participation
Reason: ____

Recommendations:
____
____
____

Examining Physician (PRINT) ________________________ M.D / D.O. Date: _______

Address: _____________________________________ Phone Number: _____________

Medical Exam Performed By: _________________________________ Date: ________

Musculoskeletal Exam Performed By: __________________________ Date: _________

Physician Signature: __________________________________M.D / D.O. Date: ______

MEDICAL OFFICE STAMP:

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Student-Athlete Information:

Name of Athlete: ______________________________ Date of Birth: _____/_____/____
Age: ________ Sex: Male/Female Preferred Pronouns:______________________
Grade________ Date: _____/_____/_____ Telephone Number: __________________
Preferred Email: _______________________________ Student ID: ____________________
Status: New: _____ Returning: _____ Sport: ____________________________________
Students Address: ____
Parent/Emergency Contact: _______________________ Phone Number: _______________

Allergies:

Please list the following to the best of your ability.

Medications: *Please list all prescription medications you are currently taking (asthma inhalers and birth controls).*

____
____
____

Medications Continued:: *Please list all of the over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking.*

____
____
____

Do you have any allergies?: *If yes, please identify the allergy below and explain. If no, skip next section.*

☐ Yes
☐ No

☐ Medicines:____
☐ Pollens: ____
☐ Foods: ____
☐ Insect Stings: ____
☐ Other: ____

Do you have/use an epi-pen for allergies: *If yes, please state where epi-pen is kept.*

☐ Yes
☐ No

____
____
____

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Hospitalization:

Please answer the following questions to the best of your ability.

Have you ever been hospitalized in the past two years? *Was it due to an injury? Was it due to a medical condition? If yes, please explain on the provided lines below. If no, skip to next question.*

☐ Yes
☐ No

____
____
____

Have you ever required surgery for any medical illness or injury? *If yes, please explain on the provided lines below. If no, skip to next question.*

☐ Yes
☐ No

____
____
____

Medical History:

Please answer the following questions to the best of your ability. It is imperative to answer each question with accuracy and honesty. If you answer "yes" to any of the following questions listed below, please explain in detail on the provide lines. Circle any questions you are unsure/don't understand.

Question	Yes	No
2. Have you had a medical illness or injury since last checkup or sports physical? If yes, explain: ______________________	☐ Yes	☐ No
1. Has a doctor ever denied or restricted your participation in sports for any reason? If yes, explain: ______________________	☐ Yes	☐ No
3. Do you have any ongoing medical conditions? (Example; asthma, diabetes, anemia, infections) If yes, explain: ______________________	☐ Yes	☐ No
6. Do you have any concerns regarding your health? If yes, explain: ______________________	☐ Yes	☐ No
4. Have you been diagnosed or treated for ADHD/ADD or dyslexia? If yes, explain: ______________________	☐ Yes	☐ No
5. Have you been diagnosed or treated for depression, anxiety, or other psychiatric disorder? If yes, explain: ______________________	☐ Yes	☐ No
7. Have you ever had a rash or hives develop during or after physical activity? If yes, explain: ______________________	☐ Yes	☐ No
Have you ever had any exercise-related dehydration, heat cramps, or heat stroke? If yes, explain: ______________________	☐ Yes	☐ No

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Question	Yes	No
Have you ever become ill from exercising in heat? If yes, explain: ______________________	☐ Yes	☐ No
Have you ever been dizzy during or after physical activity? If yes, explain: ______________________	☐ Yes	☐ No
Have you ever passed out during or after physical activity? If yes, explain: ______________________	☐ Yes	☐ No
Have you ever had chest pain, tightness or pressure during or after physical activity? If yes, explain: ______________________	☐ Yes	☐ No
Have you ever had your heartbeat very fast (racing), or skipped heartbeats? If yes, explain: ______________________	☐ Yes	☐ No
Have you ever had high blood pressure? If yes, explain: ______________________	☐ Yes	☐ No
Have you ever been told you have a heart murmur? If yes, explain: ______________________	☐ Yes	☐ No
Have you ever had a severe heart infection? (Example; myocarditis or pericarditis? If yes, explain: ______________________	☐ Yes	☐ No
Have you ever had a severe viral infection within the last month? (Example: mononucleosis)? If yes, explain: ______________________	☐ Yes	☐ No
Have you ever been diagnosis with sickle cell or sickle cell trait? If yes, explain: ______________________	☐ Yes	☐ No
Do you currently have any skin problems (Example; itching, rashes, acne, warts, fungus)? If yes, explain: ______________________	☐ Yes	☐ No
Have you ever sustained any type of head or face injury? If yes, explain: ______________________	☐ Yes	☐ No
Have you ever been “knocked out”, become unconscious or lost your memory? If yes, explain: ______________________	☐ Yes	☐ No
Have you ever been diagnosed with a concussion? If so, indicate the number of concussions, dates, and the date of your most recent. If yes, explain: ______________________	☐ Yes	☐ No
Have you ever had a seizure? If yes, explain: ______________________	☐ Yes	☐ No
Do you have frequent or severe headaches? If yes, explain: ______________________	☐ Yes	☐ No
Have you had numbness or tingling in your arms, hands, legs, or feet? If yes, explain: ______________________	☐ Yes	☐ No
Have you ever had a stinger, burner, or pinched nerve? If yes, explain: ______________________	☐ Yes	☐ No
Do you cough, wheeze or have trouble breathing during or after activity? If yes, explain: ______________________	☐ Yes	☐ No

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Do you have asthma? Do you carry an inhaler? Please identify what medication and how often you must administer the inhaler? If yes, explain: ______________________________	☐ Yes	☐ No
Do you use any special protective or corrective piece of equipment or device that *are not* used for sport or position? (Example; knee brace, other bracing, foot orthotics, retainer for your teeth, hearing aid, etc.)? If yes, explain: ______________________________	☐ Yes	☐ No
Have you had any problems with your eyes or vision? If yes, explain: ______________________________	☐ Yes	☐ No
Do you wear protective eyewear? If yes, explain: ______________________________	☐ Yes	
Do any of your joints become painful, swollen, feel warm, or look red? If yes, explain: ______________________________	☐ Yes	☐ No
Do you often have trouble sleeping? If yes, explain: ______________________________	☐ Yes	☐ No
Do you ruminate (think about things over and over) on things? If yes, explain: ______________________________	☐ Yes	☐ No
Do you feel anxious or nervous most of the time? If yes, explain: ______________________________	☐ Yes	☐ No
Have you felt sad and depressed more then usual? If yes, explain: ______________________________	☐ Yes	☐ No
Do you have a hard time managing emotions (Example: anger)? If yes, explain: ______________________________	☐ Yes	☐ No
Have you recently thought of hurting yourself or others? If yes, explain: ______________________________	☐ Yes	☐ No
Do you worry about your weight? If yes, explain: ______________________________	☐ Yes	☐ No
Do you want to weigh more or less than you do now? If yes, explain: ______________________________	☐ Yes	☐ No
Are you on a special diet or do you avoid certain types of foods? If yes, explain: ______________________________	☐ Yes	☐ No
Have you ever had an eating disorder (Example; anorexia nervosa, bulimia nervosa, etc.)? If yes, explain: ______________________________	☐ Yes	☐ No

Family History:

Please answer the following questions to the best of your ability.

Has a close relative had any heart problems and/or uses a pacemaker or implanted defibrillator? If yes, explain: ______________________________	☐ Yes	☐ No

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Question	Yes	No
Has a family member or relative died of heart problems or sudden death before the age of 50? If yes, explain: ______________________	☐ Yes	☐ No
Is there a family history of heart problems in a close relative younger than there age of 50? (Example; abnormal heart rhythm, abnormal EKG, etc.) If yes, explain: ______________________	☐ Yes	☐ No
Is there a family history of Marfan's Syndrome? Who? If yes, explain: ______________________	☐ Yes	☐ No
Is there a family history of Diabetes? Who? If yes, explain: ______________________	☐ Yes	☐ No
Is there a family history of Cancer? Who? What Type? If yes, explain: ______________________	☐ Yes	☐ No

Females Only:

Please answer the following questions to the best of your ability.

Question	Yes	No
Have you ever had a menstrual period? If yes, explain: ______________________	☐ Yes	☐ No
How old were you when you had your first menstrual period? If yes, explain: ______________________	☐ Yes	☐ No
Do you have irregular or heavy menstrual periods? If yes, explain: ______________________	☐ Yes	☐ No
Approximately, how many times a year do you have your period? If yes, explain: ______________________	☐ Yes	☐ No

Miscellaneous:

Please answer the following questions to the best of your ability.

Question	Yes	No
Do you have any medical illness or injury which have not been mentioned? If yes, explain: ______________________	☐ Yes	☐ No
Are you currently being treated by a physician? If yes, explain: ______________________	☐ Yes	☐ No

Orthopedic History:

Have you broken and/or fractured any of the following bones? CHECK ALL THAT APPLY. Please provide YEAR and TYPE of injury to the best of your ability.

☐ Skull (R/L):	☐ Femur (R/L):	☐ Clavicle (R/L):
☐ Face (R/L):	☐ Patella (R/L):	☐ Humerus (R/L):

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☐ Neck (R/L):	☐ Tibia (R/L):	☐ Radius (R/L):
☐ Spine (R/L):	☐ Fibula (R/L):	☐ Ulna (R/L):
☐ Ribs (R/L):	☐ Foot (R/L):	☐ Hand (R/L):
☐ Pelvis (R/L):	☐ Toes (R/L):	☐ Fingers (R/L):

Have you dislocated or sprained any of the following joints? CHECK ALL THAT APPLY. Please provide YEAR and TYPE of injury to the best of your ability.

☐ Neck (R/L):	☐ AC (R/L):	☐ Hand (R/L):	☐ SI (R/L):
☐ Back(R/L):	☐ Elbow (R/L):	☐ Fingers (R/L):	☐ Knee (R/L):
☐ Ribs (R/L):	☐ Wrist (R/L):	☐ Hip (R/L):	☐ SI (R/L):
☐ Shoulder (R/L):			

Have you ever strained any of the following muscles? CHECK ALL THAT APPLY. Please provide YEAR and TYPE of injury to the best of your ability.

☐ Neck (R/L):	☐ Abdominal (R/L):
☐ Shoulder (R/L):	☐ Glutes (R/L):
☐ Upper Back (R/L):	☐ Groin (R/L):
☐ Lower Back (R/L):	☐ Hamstring (R/L):
☐ Upper Arm (R/L):	☐ Quad (R/L):
☐ Forearm (R/L):	☐ Lower Leg (R/L):

I hearty certify, to the best of my knowledge, that the medical information given to the above questions are complete and correct. I understand that any incorrect information may disqualify me from participation at Buena Park High School, and also relieves Buena Park High School of all medical-legal liability.

Permission for Treatment:

In case of routine health examinations, diagnostic procedures, treatment of illness and/or injuries, permission is granted to treat the student listed above at Buena Park High School, and to make necessary referrals as indicated.

X ______________________________ ______________

Athlete's Signature Date

X ______________________________ ______________

Parent/Guardian's Signature Date