

**MOUNT BAKER SCHOOL DISTRICT  
PREPARTICIPATION HISTORY AND PHYSICAL EXAMINATION**

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Exam Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

**HISTORY**

- |       | Yes                      | No                       |                                                                                                    |
|-------|--------------------------|--------------------------|----------------------------------------------------------------------------------------------------|
| 1 a.  | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any illness/injury recently, or do you have an illness/injury now?                    |
| b.    | <input type="checkbox"/> | <input type="checkbox"/> | Have you had a medical problem, illness or injury since your last exam?                            |
| c.    | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any chronic or recurrent illness?                                                      |
| d.    | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any illness lasting more than a week?                                            |
| e.    | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been hospitalized overnight?                                                         |
| f.    | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any surgery other than tonsillectomy?                                                 |
| g.    | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any injuries requiring treatment by a physician?                                 |
| h.    | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any organ missing other than tonsils ( appendix, eye, kidney, testicle, etc.)?         |
| 2.    | <input type="checkbox"/> | <input type="checkbox"/> | Are you presently taking ANY medications ( including birth control pill, vitamin, aspirin, etc.)?  |
| 3.    | <input type="checkbox"/> | <input type="checkbox"/> | Do you have ANY allergies (medicines, bees, foods, or other factors)?                              |
| 4 a.  | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had chest pain, dizziness, fainting, passing out during or after exercise?           |
| b.    | <input type="checkbox"/> | <input type="checkbox"/> | Do you tire more easily or quickly than your friends during exercise?                              |
| c.    | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any problem with your blood pressure or your heart?                              |
| d.    | <input type="checkbox"/> | <input type="checkbox"/> | Have any close relatives had heart problems, heart attack or sudden death before they were age 50? |
| 5.    | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any skin problems (acne, itching, rashes, etc.)?                                       |
| 6 a.  | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had fainting, convulsions, seizures or severe dizziness?                             |
| b.    | <input type="checkbox"/> | <input type="checkbox"/> | Do you have frequent severe headaches?                                                             |
| c.    | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a "stinger" or "burner" or "pinched nerve"?                                      |
| d.    | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been "knocked out" or "passed out"?                                                  |
| e.    | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a neck or head injury?                                                           |
| 7.    | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had heat exhaustion, heat stroke, heat cramps or similar heat-related problems?      |
| 8.    | <input type="checkbox"/> | <input type="checkbox"/> | Have you had asthma, or trouble breathing, or cough during or after exercise?                      |
| 9 a.  | <input type="checkbox"/> | <input type="checkbox"/> | Do you wear eyeglasses, contact lenses or protective eye wear?                                     |
| b.    | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any problem with your eyes or vision?                                                 |
| 10.   | <input type="checkbox"/> | <input type="checkbox"/> | Do you wear any dental appliance such as braces, bridge, plate, retainer?                          |
| 11 a. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a knee injury?                                                                   |
| b.    | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had an ankle injury?                                                                 |
| c.    | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever injured any other joint (shoulder, wrist, fingers, etc.)?                            |
| d.    | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a broken bone (fracture)?                                                        |
| e.    | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a cast, splint, or had to use crutches?                                          |
| f.    | <input type="checkbox"/> | <input type="checkbox"/> | Must you use special equipment for competition (pads, braces, neck roll, etc.)?                    |
| 12.   | <input type="checkbox"/> | <input type="checkbox"/> | Has it been more than 5 years since your last tetanus booster shot?                                |
| 13.   | <input type="checkbox"/> | <input type="checkbox"/> | Are you worried about your weight?                                                                 |
| 14.   | <input type="checkbox"/> | <input type="checkbox"/> | FEMALES: Have you any menstrual problems?                                                          |
| 15.   | <input type="checkbox"/> | <input type="checkbox"/> | Have you any medical concerns about participating in your sport?                                   |

\*\*\*\*\* ATHLETE SHOULD NOT WRITE BELOW THIS LINE \*\*\*\*\*

EXAMINER'S COMMENTS ON ALL "YES" ANSWERS (refer to question number):

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## PHYSICAL EXAMINATION

Name: \_\_\_\_\_

Age: \_\_\_\_\_ Pulse: \_\_\_\_\_

Height: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

Weight: \_\_\_\_\_ Visual Acuity: Left 20/ \_\_\_\_\_  
 Right 20/ \_\_\_\_\_

Optional

Urinalysis:

Body Fat %

HCT:

EST VO2 Max:

Audiometry:

Normal

Abnormal

<input type="checkbox"/>	1.	Head	<input type="checkbox"/>	
<input type="checkbox"/>	2.	Eyes (pupils), ENT	<input type="checkbox"/>	_____
<input type="checkbox"/>	3.	Teeth	<input type="checkbox"/>	_____
<input type="checkbox"/>	4.	Chest	<input type="checkbox"/>	_____
<input type="checkbox"/>	5.	Lungs	<input type="checkbox"/>	_____
<input type="checkbox"/>	6.	Heart	<input type="checkbox"/>	_____
<input type="checkbox"/>	7.	Abdomen	<input type="checkbox"/>	_____
<input type="checkbox"/>	8.	Genitalia	<input type="checkbox"/>	_____
<input type="checkbox"/>	9.	Neurologic	<input type="checkbox"/>	_____
<input type="checkbox"/>	10.	Skin	<input type="checkbox"/>	_____
<input type="checkbox"/>	11.	Physical Maturity	<input type="checkbox"/>	_____
<input type="checkbox"/>	12.	Spine, Back	<input type="checkbox"/>	_____
<input type="checkbox"/>	13.	Shoulders, Upper extremities	<input type="checkbox"/>	_____
<input type="checkbox"/>	14.	Lower extremities	<input type="checkbox"/>	_____

Assessment:  Full participation  
 Limited participation (describe limitations, restrictions):

\_\_\_\_\_

\_\_\_\_\_

Participation contraindicated (list reasons):

\_\_\_\_\_

\_\_\_\_\_

Recommendations (equipment, taping, rehabilitation, etc.):

\_\_\_\_\_

\_\_\_\_\_

DATE: \_\_\_\_\_

EXAMINER'S SIGNATURE: \_\_\_\_\_

EXAMINER'S PHONE: ( ) \_\_\_\_\_

PRINT EXAMINER'S NAME: \_\_\_\_\_