Georgetown County School District

PRE-PARTICIPATION HEALTH SCREENING FOR ATHLETICS / EXTRACURRICULAR ACTIVITIES

Name _____ **Sex: M F Grade: 7 8 9 10 11 12** (2018-2019 School Year) **Date of Birth** ___/___/___ Month / Day / Year

FIRST MIDDLE LAST

Sports you plan to play {√ all that apply} ____ **Football** ____ **Basketball** ____ **Baseball** ____ **Softball**
____ **Volleyball** ____ **Wrestling** ____ **Cross Country** ____ **Soccer** ____ **Track** ____ **Swimming**
____ **Golf** ____ **Lacrosse** ____ **Cheerleading** ____ **Tennis** ____ **NJROTC** ____ **Dance Team**

Medical History **(Answer ALL questions by checking the YES or NO boxes. Explain ALL "Yes" answers in the space below!**

	GENERAL MEDICAL HISTORY:	YES	NO	Don't Know
1.	HAVE YOU HAD ANY MEDICAL PROBLEM OR PHYSICAL INJURY SINCE YOUR LAST PHYSICAL EXAM?	☐	☐	☐
2.	DO YOU HAVE ASTHMA?	☐	☐	☐
3.	DO YOU HAVE DIABETES?	☐	☐	☐
4.	DO YOU HAVE HIGH BLOOD PRESSURE?	☐	☐	☐
5.	DO YOU HAVE SEIZURES?	☐	☐	☐
6.	DO YOU HAVE SICKLE CELL TRAIT?	☐	☐	☐
7.	HAVE YOU HAVE ANY OTHER MAJOR MEDICAL PROBLEM?	☐	☐	☐
8.	HAVE YOU EVER BEEN HOSPITALIZED OR HAD SURGERY?	☐	☐	☐
9.	DO YOU COUGH, WHEEZE, OR HAVE TROUBLE BREATHING WHEN EXERCISING?	☐	☐	☐
10.	DO YOU USE AN INHALER?	☐	☐	☐
11.	DO YOU HAVE A SINGLE ORGAN (TESTICLE OR KIDNEY)?	☐	☐	☐
12.	ARE YOU CURRENTLY TAKING ANY MEDICINES OR DO YOU TAKE ANY MEDICINES ON A REGULAR BASIS (PRESCRIPTION OR OVER-THE-COUNTER)?	☐	☐	☐
13.	HAVE YOU EVER TAKEN ANY SUPPLEMENTS OR VITAMINS TO HELP WITH WEIGHT LOSS, WEIGHT GAIN, OR TO IMPROVE PERFORMANCE?	☐	☐	☐
14.	DO YOU HAVE ANY ALLERGIES (SEASONAL, INSECTS, FOOD, OR MEDICINES)?	☐	☐	☐
15.	HAVE YOU EVER HAD A RASH OR HIVES DEVELOP DURING OR AFTER EXERCISE?	☐	☐	☐
16.	DO YOU HAVE ANY SKIN PROBLEMS OTHER THAN ACNE?	☐	☐	☐
17.	HAVE YOU EVER HAD A HEAD INJURY, BEEN KNOCKED OUT, LOST YOUR MEMORY, HAD YOUR "BELL RUNG", OR A CONCUSSION?	☐	☐	☐
18.	HAVE YOU EVER HAD NUMBNESS OR TINGLING IN YOUR ARMS, HANDS, LEGS, OR FEET?	☐	☐	☐
19.	HAVE YOU EVER HAD A "STINGER", "BURNER", OR PINCHED NERVE?	☐	☐	☐
20.	HAVE YOU EVER BECOME ILL FROM EXERCISING IN THE HEAT?	☐	☐	☐
21.	HAVE YOU HAD MONONUCLEOSIS OR ANY SIGNIFICANT ILLNESS IN THE LAST 60 DAYS?	☐	☐	☐
22.	DO YOU HAVE TROUBLE WITH YOUR EYES/VISION/WEAR GLASSES OR CONTACTS?	☐	☐	☐
23.	DO YOU HAVE TROUBLE WITH YOUR HEARING/WEAR HEARING AIDS?	☐	☐	☐
24.	DO YOU WANT TO WEIGH MORE OR LESS THAN YOU DO NOW?	☐	☐	☐
25.	DO YOU LOSE WEIGHT REGULARLY TO MEET WEIGHT REQUIREMENTS FOR YOUR SPORT OR OTHER REASONS	☐	☐	☐
26.	DO YOU FEEL STRESSED OUT, OVERLY TIRED, OR DEPRESSED?	☐	☐	☐
27.	ARE THERE ANY OTHER ISSUES YOU WOULD LIKE TO DISCUSS WITH THE DOCTOR?	☐	☐	☐
	CARDIAC HISTORY:			
1.	HAVE YOU EVER PASSED OUT DURING OR AFTER EXERCISE	☐	☐	☐
2.	HAVE YOU EVER BEEN DIZZY DURING OR AFTER EXERCISE?	☐	☐	☐
3.	HAVE YOU EVER HAD CHEST PAIN OR CHEST PRESSURE DURING OR AFTER EXERCISE?	☐	☐	☐
4.	DO YOU TIRE EASILY OR MORE QUICKLY THAN YOUR FRIENDS DURING EXERCISE?	☐	☐	☐
5.	HAVE YOU EVER HAD RACING OF YOUR HEART OR SKIPPED HEARTBEATS?	☐	☐	☐
6.	HAVE YOU EVER BEEN TOLD YOU HAD A HEART MURMUR?	☐	☐	☐
7.	HAVE YOU EVER BEEN TOLD YOU HAD AN ENLARGED HEART?	☐	☐	☐
8.	HAS ANY MEMBER OF YOUR FAMILY:	☐	☐	☐
	☐ - DIED OF HEART PROBLEMS OR SUDDEN DEATH BEFORE AGE 50? ☐ - BEEN TOLD THEY HAD A SERIOUS HEART PROBLEM BEFORE AGE 50 ☐ - BEEN TOLD THEY HAD MARFAN'S SYNDROME			
9.	HAS A PHYSICIAN EVER DENIED OR RESTRICTED YOUR PARTICIPATION IN SPORTS?	☐	☐	☐
	ORTHOPAEDIC HISTORY:			
1.	HAVE YOU EVER BROKEN OR FRACTURED ANY BONES?	☐	☐	☐
2.	HAVE YOU EVER DISLOCATED OR PARTIALLY DISLOCATED ANY JOINT?	☐	☐	☐
3.	HAVE YOU HAD ANY PROBLEMS RELATED TO YOUR:	☐	☐	☐
	☐ - NECK, SPINE, OR BACK ☐ – SHOULDERS ☐ – ELBOWS ☐ -WRISTS, HANDS, OR FINGERS ☐ – HIPS ☐ – KNEES ☐ - ANKLES, FEET, OR TOES ☐ - OTHER			
	FEMALES ONLY:			
1.	ARE YOUR PERIODS REGULAR (EVERY MONTH)?	☐	☐	☐
2.	ARE YOUR PERIODS HEAVY?	☐	☐	☐
3.	WHEN WAS YOUR FIRST PERIOD? MONTH _____ YEAR _____			
4.	WHEN WAS YOUR LAST PERIOD? MONTH _____ YEAR _____			

Please explain YES answers from above in this space:

_____

_____

Signature of parent/guardian: _____ **Date signed:** _____

***A photocopy or facsimile of this document shall be considered the same as the original document.*

Please note...Per South Carolina High School League rules, pre-participation physicals are valid from April 1, 2018– May 31, 2019

PPE FORMS 2018-2019 SCHOOL YEAR

Pre-participation Health Screening Examination

Date of Examination: _____

Physical Examination

Name: _____ **Age:** _____ **Date of Birth:** ____/____/____

COMPLETE

LIMITED

HEIGHT _____ WEIGHT _____

PULSE _____ BP _____/_____ RESPIRATION _____

VISION R 20/_____ L 20/ _____ CORRECTED (CIRCLE): YES / NO
IF YES, WITH? (CIRCLE) GLASSES / CONTACTS

	NORMAL	ABNORMAL FINDINGS	INITIALS
CARDIOPULMONARY			
PULSES (INCLUDING FEMORAL)			
HEART (SUPINE & SQUAT TO STANDING)			
LUNGS			
SKIN			
ABDOMINAL			
GENITALIA			

MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS	INITIALS
NECK			
SHOULDERS			
ELBOWS			
WRISTS			
HANDS			
BACK/SPINE			
HIP/PELVIS			
KNEES			
ANKLES			
FEET			

DENTAL EXAM	NORMAL	ABNORMAL FINDINGS	INITIALS
GUMS AND TONGUE			
TEETH			
TMJ JOINT			

Clearance (check one): ☐ CLEARED ☐ Cleared ***after*** completing evaluation/treatment for: _____

☐ **NOT CLEARED** for sport/activity (list) _____

☐ **NOT CLEARED FOR ANY SPORTS PARTICIPATION** due to: _____

Other recommendations: _____

Name of Examining Physician: _____ Phone Number: _____

Physician Office Name: _____

Signature of Examining Physician: _____ Date: _____