

Athletic Pre-Participation Screening Exam 2020-2021

The parent/guardian and student athlete will review and submit the Permit to Participate in Athletics (not this form) electronically by completing the SportsNet Online Registration.

Part 1: (To be completed by student and parent/guardian)

Name _____ School _____ Grade _____
 Address _____ Student ID # _____
 City _____ State _____ Zip _____ Phone _____
 Age _____ Birth Date _____ Sex _____ Sport(s) _____
 Doctor's Name _____ Doctor's Phone # _____
 Health Insurance _____ Policy # _____

IMMUNIZATION RECORDS FOR THE ABOVE NAMED STUDENT MUST BE ATTACHED AND CURRENT AS REQUIRED BY CALIFORNIA STATE LAW INCLUDING THE Tdap VACCINE.

Health History (must be complete prior to the exam)

Please check		Has this student had any:	Please check		Is there a history of:
Y <input type="checkbox"/>	N <input type="checkbox"/>	Hospitalization?	Y <input type="checkbox"/>	N <input type="checkbox"/>	Neck or back injury?
Y <input type="checkbox"/>	N <input type="checkbox"/>	Surgery other than removal of tonsils?	Y <input type="checkbox"/>	N <input type="checkbox"/>	Knee injury?
Y <input type="checkbox"/>	N <input type="checkbox"/>	Missing organs (eye, kidney, testicle, etc.)?	Y <input type="checkbox"/>	N <input type="checkbox"/>	Shoulder or elbow injury?
Y <input type="checkbox"/>	N <input type="checkbox"/>	Allergies (to medicines, insects, foods, etc.)?	Y <input type="checkbox"/>	N <input type="checkbox"/>	Ankle injury?
Y <input type="checkbox"/>	N <input type="checkbox"/>	Chest pain or severe shortness of breath with exercise?	Y <input type="checkbox"/>	N <input type="checkbox"/>	Dislocation of a joint?
Y <input type="checkbox"/>	N <input type="checkbox"/>	Problems with blood pressure or heart (i.e. heart murmur)?	Y <input type="checkbox"/>	N <input type="checkbox"/>	Catching or locking of a joint?
Y <input type="checkbox"/>	N <input type="checkbox"/>	Dizziness or fainting with exercise?	Y <input type="checkbox"/>	N <input type="checkbox"/>	Broken bones/fractures?
Y <input type="checkbox"/>	N <input type="checkbox"/>	Severe or frequent headaches?	Y <input type="checkbox"/>	N <input type="checkbox"/>	Ulcers or hernias?
Y <input type="checkbox"/>	N <input type="checkbox"/>	Concussion or loss of consciousness?	Y <input type="checkbox"/>	N <input type="checkbox"/>	Stingers/burners?
Y <input type="checkbox"/>	N <input type="checkbox"/>	Heat exhaustion, heat stroke or other problems with heat?	Y <input type="checkbox"/>	N <input type="checkbox"/>	Skin problems?
Y <input type="checkbox"/>	N <input type="checkbox"/>	Mono, hepatitis, hemophilia?	Further History		
Y <input type="checkbox"/>	N <input type="checkbox"/>	Diabetes?	Y <input type="checkbox"/>	N <input type="checkbox"/>	Has any family member died suddenly at less than 40 years of age of causes other than an accident?
Y <input type="checkbox"/>	N <input type="checkbox"/>	Seizures/convulsions?	Y <input type="checkbox"/>	N <input type="checkbox"/>	Has any family member had a heart attack at less than 55 years of age?

Use this space to explain any yes answers to the above questions.

Parent's or guardian's acknowledgment: I have reviewed and agree with the information presented on this form. I also understand that this examination is primarily for sports participation screening and is not intended to replace the routine health care visits as recommended by the student's personal physician. I know of no reason why the above named student should not participate and represent his or her school in supervised athletic activities.

Name of Parent/Guardian (Print)

Signature of Parent/Guardian

Home Phone Number

Work Phone Number

Date

Athletic Pre-Participation Screening Exam Part 2: General Exam (To be completed by examining physician)

	Normal	Abnormal (Describe)	Fill in Information:
Eyes, ears, nose, throat	<input type="checkbox"/>	_____	Pulse: _____
Skin	<input type="checkbox"/>	_____	BP: _____
Lungs	<input type="checkbox"/>	_____	Height: _____
Heart	<input type="checkbox"/>	_____	Weight: _____
Abdomen	<input type="checkbox"/>	_____	Date of Physical Exam:
Genitalia/Hernia (males)	<input type="checkbox"/>	_____	

Suggested Musculoskeletal Exam

ROM STRENGTH

Normal	Abnormal	Cervical/Spine	Normal	Abnormal	Lower Extremity
<input type="checkbox"/>	<input type="checkbox"/>	Flex/Ext	<input type="checkbox"/>	<input type="checkbox"/>	Hip
<input type="checkbox"/>	<input type="checkbox"/>	Rotation right/left	<input type="checkbox"/>	<input type="checkbox"/>	Hip flexors/Gluteals
<input type="checkbox"/>	<input type="checkbox"/>	Lateral flexion right/left	<input type="checkbox"/>	<input type="checkbox"/>	Add/Abd – Groin/TT
<input type="checkbox"/>	<input type="checkbox"/>	Thoracic	<input type="checkbox"/>	<input type="checkbox"/>	Int./Ext. Rotation
<input type="checkbox"/>	<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	<input type="checkbox"/>	Knee
<input type="checkbox"/>	<input type="checkbox"/>	Flex/Ext	<input type="checkbox"/>	<input type="checkbox"/>	Patellar Tendon
<input type="checkbox"/>	<input type="checkbox"/>	Rotation right/left	<input type="checkbox"/>	<input type="checkbox"/>	Tibial Tuberosity
<input type="checkbox"/>	<input type="checkbox"/>	Lateral Flexion	<input type="checkbox"/>	<input type="checkbox"/>	MCL/LCL
<input type="checkbox"/>	<input type="checkbox"/>	Abdominals/Obliques	<input type="checkbox"/>	<input type="checkbox"/>	ACL/PCL
		Upper Extremity			Cartilage Testing
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	Quads/Hamstrings
<input type="checkbox"/>	<input type="checkbox"/>	Forward Flexion/Ext.	<input type="checkbox"/>	<input type="checkbox"/>	Gast/Soleus Complex
<input type="checkbox"/>	<input type="checkbox"/>	Abduction/Adduction	<input type="checkbox"/>	<input type="checkbox"/>	Patella
<input type="checkbox"/>	<input type="checkbox"/>	Internal/Ext. Rotation	<input type="checkbox"/>	<input type="checkbox"/>	Crepitus
<input type="checkbox"/>	<input type="checkbox"/>	Horizontal Abd/Add	<input type="checkbox"/>	<input type="checkbox"/>	Tracking
<input type="checkbox"/>	<input type="checkbox"/>	A C Joint/Clavicle	<input type="checkbox"/>	<input type="checkbox"/>	Ankle
<input type="checkbox"/>	<input type="checkbox"/>	Stability Testing	<input type="checkbox"/>	<input type="checkbox"/>	Plantar/Dorsiflexion
<input type="checkbox"/>	<input type="checkbox"/>	Biceps Flex/Ext.	<input type="checkbox"/>	<input type="checkbox"/>	Inversion/Eversion
<input type="checkbox"/>	<input type="checkbox"/>	Elbow	<input type="checkbox"/>	<input type="checkbox"/>	Subtalar Joint
<input type="checkbox"/>	<input type="checkbox"/>	Supination/Pronation	<input type="checkbox"/>	<input type="checkbox"/>	Ligament Testing
<input type="checkbox"/>	<input type="checkbox"/>	Wrist/Hand	<input type="checkbox"/>	<input type="checkbox"/>	Feet/Toes
		General Flexibility			
<input type="checkbox"/>	<input type="checkbox"/>	Hamstrings			
<input type="checkbox"/>	<input type="checkbox"/>	Quadriceps			
<input type="checkbox"/>	<input type="checkbox"/>	Lumbar Spine			
<input type="checkbox"/>	<input type="checkbox"/>	Achilles			

WOODSIDE WILDCATS

DOCTOR'S OFFICE STAMP HERE

REQUIRED

Use this space to describe abnormalities.

Disposition:

- Cleared for collision, contact, and non-contact sports
- Conditional participation, limited to: _____
- No participation until: (date) _____
- No participation in any sport or physical education because of: _____

Dr. Signature: _____ License #: _____ Date: _____

•PHYSICAL MUST BE PERFORMED BY A LICENSED, PRACTICING MD OR NP (No Chiropractors) & MUST BE VALID FOR THE DURATION OF THE 2020-2021 SCHOOL YEAR•

Physical will be valid for 1 YEAR from the Date of Physical Exam.