

Upper Columbia Academy Varsity Sports & Gymnastics Athletic Participation Form

Part I – Athlete Information

To be completed by athlete)

Name _____ School Year _____ Grade _____

Home Address _____

I am planning to participate in the following sports _____

Part II – Medical History

This form must be completed by parent and athlete prior to the time of the physical exam and presented to the health care provider before the physical.)

Check the appropriate response to each item

	Yes	No	Explain "Yes" Answer
1. Have you ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever had surgery of any kind?	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Are you presently taking any medications or pills?	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Have you ever passed out during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever been told you had a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever had racing of your heart?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Has anyone in your family died of heart problems before 50?	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Do you have any skin problems? (itching, rash, acne)	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Have you ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever been knocked out or unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever had a seizure or suffered from epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever had a stinger, burner or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Have you ever had heat related problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever been dizzy or passed out in the heat?	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Do you cough heavily, or breathe heavily during activity?	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Do you use any special equipment (e.g. knee brace)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. Have you ever sprained/strained, dislocated, fractured, broken,	<input type="checkbox"/>	<input type="checkbox"/>	_____
or had repeated swelling or other injuries of any bones?	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. Are you missing one of any paired organs (e.g. eyes)	<input type="checkbox"/>	<input type="checkbox"/>	_____
12. Have you ever been diagnosed with any form of asthma?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you using an inhaler for asthma?	<input type="checkbox"/>	<input type="checkbox"/>	_____
13. Are you diabetic?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you administer insulin to yourself?	<input type="checkbox"/>	<input type="checkbox"/>	_____
14. Do you have a history of sickle-cell anemia in your family?	<input type="checkbox"/>	<input type="checkbox"/>	_____
15. Have you had any other medical problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
16. Have you had a medical problem or injury within the last year?	<input type="checkbox"/>	<input type="checkbox"/>	_____
17. When was your last tetanus shot?			_____

Additional information about any "Yes" answers from questions 1 – 17 _____

Part III – Physical Examination

(To be completed by Health Care Provider)

Name _____ Date of Birth _____ Gender _____

Height _____ Weight _____ Blood Pressure _____ / _____ Pulse _____

	Normal	Abnormal	Comment
Heart			
Rhythm (Reg/irreg)			
Murmur (supine)			
Murmur (standing)			
ENT			
Lungs			
Skin			
Abdomen			
Musculoskeletal			
Neck			
Shoulder			
Elbow			
Wrist			
Hand			
Back			
Knee			
Ankle			
Foot			
Other			

I have reviewed the data above, reviewed the student's medical history and make the following recommendations on participation in athletics:

1. Cleared _____
2. Cleared after additional evaluation for _____
3. Restricted from participating in the sports of _____
4. Cleared to participate in the sports of _____

Recommendations _____

Signature of Health Care Provider _____ Date _____

Name of Health Care Provider (please print) _____

Address _____ Phone _____