The South Carolina Independent School Association

Pre-Participation History & Health Assessment Form

This form is to be filled out by the parent(s) and student prior to seeing the physician and presented to the physician at the time of the student's physical examination. The physician should keep this form with the student's records. A copy of this form will be submitted with the student's completed physical examination form to the school.

Date that this form is being completed: ______________________________

Name ________________________________ Date of Birth: ___________________ Grade: _________

School: ________________________________ Sex: F ___ M ___ Sports: _________________________

Address: ____ Phone: _____________________

Personal Physician: _______________________________________ Phone: _______________________

In Case of an Emergency Contact: ______________________________ Relationship: _______________

Home Phone #: _____________________ Cell #: _____________________ Other: ________________

Attention parent or guardian and athlete: answers to the following questions are very important! Please take the time to answer each question to the best of your knowledge.

Medicines and Allergies:

List all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are taking.

____

____

____

Do you have any allergies? ☐ **Yes** ☐ **No**

If yes, please identify specific al- lergy below.

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects ☐ Other ______________________________

Please pro- vide a de- scription of cause and treatment:

____

____

____

Concussions:

Have you ever had a head injury or concussion? ☐ **Yes** ☐ **No** *If yes, when (date)*: ____________________

Have you had more than one head injury or concussion? ☐ **Yes** ☐ **No** *If yes, how many?* _________

Provide the date of each concussion:

____

Have you ever had a blow to the head that caused confusion, prolonged headache, or memory loss? ☐ **Yes** ☐ **No**

Parent's Permission & Acknowledgement of Risk for Son or Daughter to Participate in Athletics

As the parent or legal guardian of the above named student athlete, I give my permission for his/her participation in athletic events and the physical evaluation for that participation. I grant permission for treatment deemed necessary for a condition arising during participation in these events, including medical or surgical treatment that is recommended by a medical doctor. I grant permission to nurses, trainers, coaches, doctors or those under their direction who are part of the athletic injury prevention or treatment, to have access to necessary medical information. I know that the risk of injury to my child/ward comes with participation in sports and during travel to and from play and practice. My signature indicates that to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete ____ Date ______________________

Signature of parent/guardian ______________________________________ Date ______________________

Pre-Participation Physical Evaluation Medical History Questionnaire

Note: This form is to be filled out by the parent(s) and student prior to seeing the physician.

Student's Name ____ Today's Date ____________________

Attention parent or guardian and athlete: answers to the following questions are very important! Please take the time to answer each question to the best of your knowledge. Explain "Yes" answers below. Circle question if you do not know the answer.

General Questions	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions, If so Identify: ☐Asthma ☐Anemia ☐Diabetes ☐Infections Other: ______________________________		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
Heart Heath Questions About You	**Yes**	**No**
5. Have you ever passed out or nearly passed out during or after exercise?		
6. Have you ever had pain, discomfort, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip a beat (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High Blood Pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease ☐ Other: ___________________		
9. Has a doctor ever ordered a test for your heart?		
10. Do you get lightheaded or feel more short of breath more than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
Health Questions About Your Family	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected sudden death before age 50 (*including drowning, unexplained car accident, sudden death syndrome*)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic, polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures or near drowning?		
Bone and Joint Questions	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament or tendon that caused you to miss a game or practice?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Do you regularly use a brace, orthotics, or other assistive device?		
22. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		
Medical Questions	**Yes**	**No**
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) in the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Do you have a history of seizure disorder?		
35. Do you have headaches with exercise?		
36. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
37. Have you ever been unable to move your arms or legs after being hit or falling?		
38. Have you ever become ill while exercising in the heat?		
39. Do you get frequent muscle cramps when exercising?		
40. Do you or someone in your family have sickle cell trait or disease?		
41. Have you had any problems with your eyes or vision?		
42. Have you had any eye injuries?		
43. Do you wear glasses or contact lenses?		
44. Do you wear protective eyewear, such as goggles or a face shield?		
45. Do you worry about your weight?		
46. Are you trying or has anyone recommended that you gain or lose weight?		
47. Are you on a special Diet or do you avoid certain types of foods?		
48. Have you ever had an eating disorder?		
49. Do you have any concerns that you would like to discuss with a doctor?		
Females Only	**Yes**	**No**
50. Have you ever had a menstrual period?		
51. How old were you when you had your first menstrual period?		
52. How many periods have you had in the past 12 months?		

Explain any "YES" answers on an additional page and attach to this questionnaire.

I hereby state that, to best of my knowledge, my answers to the above questions are complete and correct.

Athlete's Signature ________________________________

Parent/Guardian Signature ________________________________

Date ____________________________