FULTON COUNTY STUDENT PREPARTICIPATION MEDICAL HISTORY / PHYSICAL EXAMINATION FORM

This form is to be completed by the Parent/Guardian/Student and returned to the coach prior to the first practice session.

Student Name: _____ Male __ / Female __ DOB: _____
(Last Name) (First Name) (MI) (Month) (Day) (Year)

Address: _____ Home Tel, #: _____
(# and Street Name) (City) (State) (Zip Code)

Emergency Tel. # _____ Cellular Tel. #: _____ Grade this school year: 6 7 8

Name(s) of parent(s) /guardian(s) you live with: _____.

In Case of Emergency Contact: _____ Relationship: _____ Tel. #: _____

Personal Physician's Name: _____ Tel. #: _____

Explain "YES" answers in the item spaces provided on next page. Circle #s to questions that you do not know the answers.

#	MEDICAL QUESTION	YES	NO	#	MEDICAL QUESTION	YES	NO
1	Have you had a medical illness or injury since your last check up or sports physical?			24	Do you have frequent or severe headaches?		
2	Have you ever been hospitalized overnight?			25	Have you ever had numbness or tingling in your arms, hands, legs, or feet?		
3	Have you ever had surgery?			26	Have you ever had a stinger, burner, or pinched nerve?		
4	Are you currently taking any prescription or non prescription (over- the-counter) medications or pills or using an inhaler?			27	Have you ever become ill from exercising in the heat?		
5	Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?			28	Do you cough, wheeze, or have trouble breathing during or after activity?		
6	Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?			29	Do you have asthma?		
7	Have you ever had a rash or hives develop during or after exercise?			30	Do you have seasonal allergies that require medical treatment?		
8	Have you ever passed out during or after exercise?			31	Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?		
9	Have you ever been dizzy during or after exercise?			32	Have you had any problems with your eyes or vision?		
10	Have you ever had chest pain during or after exercise?			33	Do you wear glasses, contact lenses, or protective eyewear?		
11	Do you get tired more quickly than your friends do during exercise?			34	Have you ever had a sprain, strain, or swelling after injury?		
12	Have you ever had racing of your heart or skipped heartbeats?			35	Have you broken or fractured any bones or dislocated any joints?		
13	Have you had high blood pressure or high cholesterol?			36	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?		
14	Have you ever been told you have a heart murmur?			37	*If yes to Question # 36 then circle the part of the body below:*		
15	Has your family member or relative died of heart problems or of sudden death before age 50?				**Head Elbow Hip Neck Forearm Thigh**		
16	Have you or any family member or relative been diagnosed with diabetes before age 50?				**Back Wrist Knee Chest Hand Finger**		
17	Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?				**Shin/calf Foot Ankle Shoulder Upper arm**		
18	Has a physician ever denied or restricted your participation in sports for any heart problem?						
19	Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?						
20	Have you ever had a head injury or concussion?						
21	Have you ever been knocked out, become unconscious, or lost your memory?			38	Do you want to weigh more or less than you do now?		
22	Have you ever had a seizure?			39	Do you lose weight regularly to meet weight requirements for your sport?		
23	Is there a history of Marfan's Syndrome in your family?			40	Do you feel stressed out?		

41	Record the dates of your most recent immunizations (shots) for: Tetanus_____ Measles _____ Hepatitis B_____ Chicken Pox _____	42	**FEMALES ONLY** When was your first menstrual period?_____ When was your most recent menstrual period?_____ How much time do you usually have from the start of one period to the start of another? _____ How many period have you had in the last year?_____ What was the longest time between periods in the last year? _____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.
Signature of Athlete: Signature of Parent/Guardian: Date:

Use these spaces to record information from "YES" answers from the Medical Questions section.

Item #	
Item #	
Item #	
Item #	
Item #	

The following part is to be completed by the examining physician for the preparticipation physical examination

Patient's Name: _____ _____ _____DOB: _____

Height: _____ Weight: _____ Pulse:_____ BP: _____ Vision: R/20 _____L20/_____

Corrected vision: Yes / No Pupils: Equal / Unequal % body fat (optional) _____

Medical	Normal	Abnormal Findings	Initials*
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Musculoskeletal			
Neck			
Back			
Shoulder / Arm			
Elbow / Forearm			
Wrist / Hand			
Hip (thigh)			
Knee			
Leg / Ankle			
Foot			

* Stationed-based examination only

☐ Physician's clearance to participate in interscholastic athletic practices and competitions.

☐ Physician's clearance to participate in interscholastic athletic practices and competitions after completing evaluation/rehabilitation for:

_____.

☐ Not cleared to participate in interscholastic athletic practices and competitions for : _____Reason: _____
Recommendations: _____

_____

Physician's Name: _____ Office Telephone: _____

Address: _____City: _____ State:_____ ZIP: _____

Physician's Signature: _____ Date: _____