Lapeer Regional Medical Center
Pre-Participation Sport Examination

Name: (Last) ______________ (First) ______________ (Middle Initial) ____ Date of Birth ______________

Grade: ______________ School: ______________ Age: ______ Sex: ______

Present Address: ______________ Telephone: ______________

Parent's Name: ______________ Work Telephone: ______________

Family Physician: ______________ Medical Insurance: ______________

Emergency Contact: ______________ Telephone: ______________

I give permission to Lapeer Regional Medical Center to provide a pre-participation sports exam to the above mentioned athlete. I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Athlete's Signature: ______________ Parent's Signature: ______________ Date: ______________

** School Administrator: See other side for recommendation of sport participation for this student-athlete (over)

PRE-PARTICIPATION PHYSICAL EXAM HISTORY FORM

Name: ______________ Sex: ______ Age: ______ Date of Birth: ______________

Grade: ______ School: ______________ Sports: ______________

Address: ______________ Phone: ______________

Personal Physician: ______________

In case of emergency, contact:

Name: ______________ Relationship: ______________ Phone (H): ______________ (W): ______________

Explain "Yes" answers below.
Circle questions you don't know the answers to.

Yes No

1) Has a doctor ever denied or restricted your participation in sports for any reason? ☐ ☐
2) Do you have an ongoing medical condition (like diabetes or asthma)? ☐ ☐
3) Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? ☐ ☐
4) Do you have allergies to medicines, pollens, foods, or stinging insects? ☐ ☐
5) Have you ever passed out or nearly passed our DURING exercise? ☐ ☐
6) Have you ever passed out or nearly passed out AFTER exercise? ☐ ☐
7) Have you ever had discomfort, pain, or pressure in your chest during exercise? ☐ ☐
8) Does your heart race or skip beats during exercise? ☐ ☐
9) Has a doctor ever told you that you have (check all that apply) ☐ ☐
   ☐ High blood pressure ☐ A heart murmur
   ☐ High cholesterol ☐ A heart infection
10) Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram) ☐ ☐
11) Has anyone in your family died for no apparent reason? ☐ ☐
12) Does anyone in your family have a heart problem? ☐ ☐
13) Has any family member or relative died of heart problems or of sudden death before age 50? ☐ ☐
14) Does anyone in your family have Marfan syndrome? ☐ ☐
15) Have you ever spent the night in a hospital? ☐ ☐
16) Have you ever had surgery? ☐ ☐

Yes No

17) Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle affected below: ☐ ☐
18) Have you had any broken or fractured bones or dislocated joints? If yes, circle below: ☐ ☐
19) Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below: ☐ ☐

Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hands/ Fingers	Chest
Upper Back	Lower Back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/toes

20) Have you ever had a stress fracture? ☐ ☐
21) Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? ☐ ☐
22) Do you regularly use a brace or assistive device? ☐ ☐
23) Has a doctor ever told you that you have asthma or allergies? ☐ ☐

Yes No

24) Do you cough, wheeze, or have difficulty breathing during or after exercise? ☐ ☐
25) Is there anyone in your family who has asthma? ☐ ☐
26) Have you ever used an inhaler or taken asthma medicine? ☐ ☐
27) Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? ☐ ☐
28) Have you had infectious mononucleosis (mono) within the last month? ☐ ☐
29) Do you have any rashes, pressure sores, or other skin problems? ☐ ☐
30) Have you had a herpes skin infection? ☐ ☐
31) Have you ever had a head injury or concussion? ☐ ☐
32) Have you ever been hit in the head and been confused or lost your memory? ☐ ☐
33) Have you ever had a seizure? ☐ ☐
34) Do you have headaches with exercise? ☐ ☐
35) Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? ☐ ☐
36) Have you ever been unable to move your arms or legs after being hit or falling? ☐ ☐
37) When exercising in the heat, do you have severe muscle cramps or become ill? ☐ ☐
38) Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? ☐ ☐
39) Have you had any problems with your eyes or vision? ☐ ☐
40) Do you wear glasses or contact lenses? ☐ ☐
41) Do you wear protective eyewear, such as goggles or a face shield? ☐ ☐
42) Are you happy with your weight? ☐ ☐
43) Are you trying to gain or lose weight? ☐ ☐
44) Has anyone recommended you change your weight or eating habits? ☐ ☐
45) Do you limit or carefully control what you eat? ☐ ☐
46) Do You:
   a. Use Steroids to improve athletic performance ☐ ☐
   b. Use any kinds of drugs ☐ ☐
   c. Drink alcohol ☐ ☐
   d. Smoke cigarettes ☐ ☐
   e. Use chewing tobacco, snuff, or dip ☐ ☐
47) Record the dates of your most recent immunization (shots) for:
   f. Tetanus __________ c. Measles __________
   g. Hepatitis B __________ d. Chicken Pox __________

FEMALES ONLY

48) Have you ever had a menstrual period? ☐ ☐
49) How old were you when you had your first menstrual period? ______
50) How many periods have you had in the last 12 months? ______

Explain "YES" answers here: ______________

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I give permission to Lapeer Regional Medical Center to provide a pre-participation sports exam to the above mentioned athlete. I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Athlete's Signature: ______________ Parent's Signature: ______________ Date: ______________

PRE-PARTICIPATION PHYSICAL EXAM — CLEARANCE FORM

Name: ______________________ Age: ________ Sex: ________ Birth Date: ______________

☐ Cleared without restrictions

☐ Not Cleared: Clearance status to be reconsidered after completion of further evaluation, treatment, or rehabilitation for:

____

____

____

☐ Not Cleared for: ☐ All Sports ☐ Certain Sports: ______________________

Recommendations: ____

____

Name of examining physician (print): ______________________ Date of Exam: ______________

Address: ______________________ Telephone: ______________

Signature of examining physician: ______________________________

PRE-PARTICIPATION PHYSICAL EXAM — PHYSICAL EXAMINATION FORM

Name: ______________________________ Birth Date: ______________

Height: __________ Weight: __________ Pulse (optional): __________ BP: ___/___, ___/___, ___/___

Pupils: Equal ____ Unequal ____

	NORMAL	ABNORMAL FINDINGS	INITIALS**
MEDICAL			
Appearance			
Eyes / ears / nose / throat			
Hearing			
Lymph Nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder / Arm			
Elbow / Forearm			
Wrist / hand / fingers			
Hip / Thigh			
Knee			
Leg / ankle			
Foot / toes			

** Only need to initial if performed other than the examining physician noted below

Notes: ____

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CLEARANCE STATUS:

☐ Cleared without restrictions

☐ Not Cleared: Clearance status to be reconsidered after completion of further evaluation, treatment, or rehabilitation for:

____

____

____

☐ Not Cleared for: ☐ All Sports ☐ Certain Sports: ______________________

Recommendations: ____

____

Date of exam: ______________

Name of examining physician (print): ______________________________

Address: ______________________ Telephone: ______________

Signature of examining physician: ______________________________