ROGUE RIVER
FAMILY PRACTICE CLINIC

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SCHOOL SPORTS PRE-PARTICIPATION EXAM

Name _____ Date of Birth _____

Address _____ Phone _____

Athlete and parent/guardian: Please review all questions and answer them to the best of your ability.
Provider: Please review with the athlete details of any positive answers.

Y	N	Maybe		
☐	☐	☐	1.	Has anyone in the athlete's family died suddenly before the age of 50 years?
☐	☐	☐	2.	Has the athlete ever passed out during exercise or stopped exercising because of dizziness or chest pain?
☐	☐	☐	3.	Does the athlete have asthma (wheezing), hay fever, or coughing spells during or after exercise?
☐	☐	☐	4.	Has the athlete ever broken a bone, had to wear a cast, or had an injury to any joint?
☐	☐	☐	5.	Does the athlete have a history of a concussion (getting knocked out) or seizures?
☐	☐	☐	6.	Has the athlete ever suffered a heat-related illness (heat stroke)?
☐	☐	☐	7.	Does the athlete have a chronic illness or see a physician regularly for any particular problem?
☐	☐	☐	8.	Does the athlete take any prescribed medicine, herb's or nutritional supplements?
☐	☐	☐	9.	Is the athlete allergic to any medications or bee stings?
☐	☐	☐	10.	Does the athlete have only one of any paired organ (eyes, ears, kidneys, testicles, ovaries, etc.)?
☐	☐	☐	11.	Has the athlete ever had prior limitation from sports participation?
☐	☐	☐	12.	Has the athlete had any episodes of shortness of breath, palpitations, history of rheumatic fever or unusual fatigability?
☐	☐	☐	13.	Has the athlete ever been diagnosed with a heart murmur or heart condition or hypertension?
☐	☐	☐	14.	Is there a history of young people in the athlete's family who have had congenital or other heart disease: cardiomyopath, abnormal heart rhythms, long QT or Marfan's syndrome? (You may write "I don t understand these terms" and initial this item, if appropriate.)
☐	☐	☐	15.	Has the athlete ever been hospitalized overnight or had surgery?
☐	☐	☐	16.	Does the athlete lose weight regularly to meet the requirements for your sport?
☐	☐	☐	17.	Does the athlete have anything he or she wants to discuss with the physician?
☐	☐	☐	18.	Does the athlete cough, wheeze, or have trouble breathing during or after activity?
☐	☐	☐	19.	Does the athlete have asthma?
☐	☐	☐	20.	**FEMALES ONLY**

a. When was your first menstrual period? _____

b. When was your most recent menstrual period? _____

c. What was the longest time between menstrual periods in the last year? _____

(Explain any **YES** *answers on back)*

Name _____ Date of Birth _____ Today's Date _____

PARENT/GUARDIAN'S STATEMENT

I have reviewed and answered the questions above to the best of ability. I and my child understand and accept that there are risks of serious injury and death in any sport, including the one(s) in which my child has chosen to participate. I hereby give permission for my child to participate in sports /activities.

I hereby authorize emergency medical treatment and/or transportation to a medical facility for any injury or illness deemed urgently necessary by a licensed athletic trainer, coach, or medical practitioner.

I understand that this sports pre-participation physical examination is not designed nor intended to substitute for any recommended regular comprehensive health assessment.

I hereby authorize release of these examination results to my child's school.

Parent/Guardian signature _____ Date _____

As per ORS 336.479, Section 1(5) "Any physical examination required by this section shall be conducted by a (a) physician possessing an unrestricted license to practice medicine: (b) licensed naturopathic physician; (c) licensed physician assistant; (d) certified nurse practitioner, or a (e) licensed chiropractic physician who has clinical training and experience in detecting cardiopulmonary diseases and defects."

Name _____ Date of Birth _____ Today's Date _____

SCHOOL SPORTS EXAM

Name _____ Date of birth _____

Height _____ Pulse _____ Vision R 20/ _____

Weight _____ BP _____ / _____ L 20/ _____

% Body Fat (optional) (_____ / _____ / _____ /) Corrected? ☐ Yes ☐ No

_____ Rhythm: ☐ Regular ☐ Irregular Pupils equal? ☐ Yes ☐ No

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS*
Appearance	☐		
Eyes/Ears/Nose/Throat	☐		
Lymph nodes	☐		
Heart: Pericardial activity	☐		
1st & 2nd heart sounds	☐		
Murmurs	☐		
Pulses: brachial/femoral	☐		
Lungs	☐		
Abdomen	☐		
Skin	☐		

MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS	INITIALS*
Neck	☐		
Back	☐		
Shoulder/Arm	☐		
Elbow/Forearm	☐		
Wrist/Hand	☐		
Hip/Thigh	☐		
Knee	☐		
Leg/Ankle	☐		
Foot	☐		

**Station-based examination only*

CLEARANCE

☐ Cleared ☐ Cleared after completing evaluation/rehabilitation for _____

☐ Not cleared for _____

Recommendations _____

Name of provider (print/type) _____ Date of birth _____

Address _____ Phone _____

Provider signature _____

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