

MILLARD PUBLIC SCHOOLS
ATHLETIC PRE-PARTICIPATION SCREENING FORM
 NOTE: A valid physical must be given after May 1, 2009

Section 1- to be filled out by parent or guardian in regard to student-athlete

Student Name _____ Date of Birth/Age _____ / _____ Grade _____

Male Female Parent/Guardian Work Phone _____ Home Phone _____

Parent/Guardian Home Address _____

Emergency Contact _____ Phone _____

Place a check by all of the sports/activity in which athlete will participate: Baseball, Basketball, Cross Country,
 Dance/Cheer, Football, Golf, Soccer, Softball, Swim/Diving, Tennis, Track, Volleyball, Wrestling

THE ACTIVITIES DEPARTMENT WOULD LIKE TO HAVE THIS INFORMATION ON FILE; HOWEVER, THERE IS NO OBLIGATION TO SUBMIT THIS PAGE TO THE SCHOOL OR DISTRICT, MEDICAL HISTORY OF STUDENT-ATHLETE: THIS HISTORY SHOULD BE COMPLETED PRIOR TO THE PHYSICAL EXAM. PLEASE CIRCLE "YES" OR "NO" FOR EACH QUESTION BELOW. IF YOU ANSWER "YES" TO ANY OF THESE QUESTIONS, PLEASE ATTACH EXPLANATIONS TO THIS SHEET. THIS PAGE MUST BE PRESENTED TO THE MEDICAL PROFESSIONAL WHO IS PERFORMING THE PHYSICAL.

Has a doctor ever denied or restricted your participation in sports for any reason?	YES NO	Has a doctor ever told you that you have high blood pressure, high cholesterol, a heart murmur, and/or a heart infection?	YES NO
Have you ever been hospitalized or ever spent the night in a hospital?	YES NO	Has a doctor ever ordered a test for your heart? (For example, an ECG, echocardiogram)	YES NO
Have you ever had surgery?	YES NO	Does your heart race or skip beats during exercise?	YES NO
Are you presently taking any prescription or non-prescription (over the counter) medication or pills?	YES NO	Does anyone in your family have a heart problem?	YES NO
Does anyone in your family have Marfan syndrome?	YES NO	Has anyone in your family died for no apparent reason?	YES NO
Do you have any allergies to medicines, pollens, foods, bee stings or other stinging insects?	YES NO	Has any family member or relative died of heart problems or of sudden death before the age of 50?	YES NO
Have you ever fainted or have you even been hit in the head and been confused or lost your memory?	YES NO	Have you ever had discomfort, pressure, or pain in your chest during or after exercise?	YES NO
Have you ever passed out, nearly passed out, been dizzy, or get headaches DURING or AFTER exercise?	YES NO	Do you have any rashes, pressure sores, or other skin problems? Have you had a herpes skin infection?	YES NO
Have you ever had a head injury, concussion, been knocked out, or been unconscious?	YES NO	Has a doctor ever told you that you have asthma or allergies? Is there anyone in your family who has asthma?	YES NO
Have you had a bone or joint injury that required X-rays, MRI, CT, injections, rehabilitation, physical therapy, a brace, a cast, or crutches?	YES NO	Do you wheeze, cough, or have trouble breathing during or after exercise?	YES NO
Have you ever had a stress fracture?	YES NO	Have you ever used an inhaler or taken asthma medicine?	YES NO
Do you regularly use a brace or assistive device?	YES NO	Have you ever had a seizure?	YES NO
Have you ever had any broken or fractured bones, or dislocated joints? If yes, please describe on a separate page.	YES NO	Have you had infectious mononucleosis (mono) within the last month?	YES NO
When exercising in the heat, have you ever had severe muscle cramps or become ill? Have you ever had heat exhaustion or a heat stroke?	YES NO	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	YES NO
Have you ever had numbness, tingling, weakness in your arms or legs, or been unable to move your arms or legs after a hit or a fall?	YES NO	Are you happy with your weight?	YES NO
Have you ever had any abnormal bleeding or bruising?	YES NO	Are you trying to gain or lose weight?	YES NO
Have you ever had an injury, like a sprain, muscle or ligament tear or tendonitis that caused you to miss a practice or game?	YES NO	Has anyone recommended that you change your weight or eating habits?	YES NO
Have you ever had any problems with your eyes or vision?	YES NO	Do you limit or carefully control what you eat?	YES NO
Do you wear glasses, contacts, or protective eyewear?	YES NO	Have you ever had any problems with your hearing?	YES NO
Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	YES NO	Do you have an ongoing medical condition (like diabetes, hepatitis, scoliosis, anemia, etc.)?	YES NO
Were you born without or are you missing a kidney, a testicle, an eye, or any other organ?		Do you have any concerns that you would like to discuss with a doctor?	

I HEREBY STATE THAT, TO THE BEST OF MY KNOWLEDGE, MY ANSWERS TO THE ABOVE QUESTIONS ARE COMPLETE AND CORRECT. I ALSO HEREBY GIVE PERMISSION FOR THE RELEASE OF THE COMPLETED MEDICAL HISTORY AND RESULTS OF THE ACTUAL PHYSICAL EXAMINATION TO THE SCHOOL FOR THE PURPOSES OF PARTICIPATION IN ATHLETICS AND ACTIVITIES.

Parent/Guardian Signature

Date

Student Signature

Date