

RENTON SCHOOL DISTRICT ATHLETIC DEPARTMENT PRE-PARTICIPATION HISTORY

Name: _____ Birth Date: _____ Grade: _____ Age: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Gender: M _____ F _____

This examination is for participation at the following level: Senior high (grades 9-12). Middle school (grades 6-8).

Athlete and Parent/Guardian: Please review all questions and answer them to the best of your ability prior to seeing your physician. Please use boxes on right as appropriate.

HISTORY

Sports you plan to play {√ all that apply}	
<input type="checkbox"/> Baseball	<input type="checkbox"/> Gymnastics
<input type="checkbox"/> Basketball	<input type="checkbox"/> Soccer
<input type="checkbox"/> Cheerleading	<input type="checkbox"/> Swimming
<input type="checkbox"/> Cross Country	<input type="checkbox"/> Tennis
<input type="checkbox"/> Diving	<input type="checkbox"/> Track
<input type="checkbox"/> Drill Team	<input type="checkbox"/> Volleyball
<input type="checkbox"/> Fast Pitch SB	<input type="checkbox"/> Wrestling
<input type="checkbox"/> Football	
<input type="checkbox"/> Golf	<input type="checkbox"/> _____

- | | Yes | No | |
|-----|--------------------------|--------------------------|--|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | a. Have you had any illness/injury recently, or do you have an illness/injury now? |
| | <input type="checkbox"/> | <input type="checkbox"/> | b. Have you had a medical problem, illness or injury since your last exam? |
| | <input type="checkbox"/> | <input type="checkbox"/> | c. Have you ever had any illness lasting more than a week? |
| | <input type="checkbox"/> | <input type="checkbox"/> | d. Have you ever been hospitalized overnight? |
| | <input type="checkbox"/> | <input type="checkbox"/> | e. Have you had any surgery other than tonsillectomy? |
| | <input type="checkbox"/> | <input type="checkbox"/> | f. Do you have any organ missing other than tonsils (appendix, eye, kidney, testicle, etc.)? |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | a. Have you ever had chest pain, dizziness, fainting, or passing out during or after exercise? |
| | <input type="checkbox"/> | <input type="checkbox"/> | b. Do you tire more easily or quickly than your friends during exercise? |
| | <input type="checkbox"/> | <input type="checkbox"/> | c. Have you ever had any problem with your blood pressure or your heart? |
| | <input type="checkbox"/> | <input type="checkbox"/> | d. Have any close relatives had Marfan's Syndrome, heart problems, heart attack, or other sudden death before they were age 50? |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | a. Have you had asthma, or trouble breathing, or cough during or after exercise? (please circle) |
| | <input type="checkbox"/> | <input type="checkbox"/> | b. Have you been prescribed an inhaler*? If Yes, Check to right if you have been told to use this inhaler prior to exercise: <input type="checkbox"/> |
| | <input type="checkbox"/> | <input type="checkbox"/> | c. Have you been prescribed a rescue inhaler*? If Yes, Check to right if you carry your rescue inhaler with you: <input type="checkbox"/> |
| | <input type="checkbox"/> | <input type="checkbox"/> | d. Check to right if your physician has trained you on the purpose, appropriate method and frequency of use for all of your inhalers? <input type="checkbox"/> |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | a. Do you have ANY allergies (medicines, bees, foods, latex, seasonal, or other factors)? |
| | | | Please detail non-seasonal: _____ |
| | <input type="checkbox"/> | <input type="checkbox"/> | b. Have you been prescribed an Epi-Pen / epinephrine auto-injector*? If Yes, Check if you carry this medication with you: <input type="checkbox"/> |
| | | | *Prior to the start of the sport, an emergency plan MUST be in place for Epi-pen or inhaler use. Contact the school nurse to set this up. |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | a. Do you have any chronic or recurrent illness (i.e. diabetes, clotting disorders, sickle-cell traits)? |
| | <input type="checkbox"/> | <input type="checkbox"/> | b. Have you been prescribed a blood sugar monitor (glucometer)? If Yes, Check to right if you carry your glucometer: <input type="checkbox"/> |
| | <input type="checkbox"/> | <input type="checkbox"/> | c. Have you been prescribed glucagon or insulin? If Yes, Check if you carry your glucagon or insulin: <input type="checkbox"/> |
| | <input type="checkbox"/> | <input type="checkbox"/> | d. Have you been prescribed medications for a clotting disorder? If Yes, Check if you carry your medications: <input type="checkbox"/> |
| | <input type="checkbox"/> | <input type="checkbox"/> | e. Do you have any other emergency medications not mentioned above? If Yes, Check if you carry these medications: <input type="checkbox"/> |
| | <input type="checkbox"/> | <input type="checkbox"/> | f. Are you presently taking or have regularly taken ANY other medications, drugs, or supplements (not limited to prescriptions)?
This includes, but is not limited to: birth control pills, vitamins, diet pills, ibuprofen, aspirin, creatine, etc.
Please circle or detail non-vitamins: _____ |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have ANY medications that you may need to take at school or while participating in a school activity (including above)?
If Yes, authorization for is required for medications to be taken at school. Check to right if you need this signed (see box). <input type="checkbox"/> |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | a. Have you ever injured any joint (ankle, knee, hip, shoulder, wrist, fingers, etc.)? |
| | <input type="checkbox"/> | <input type="checkbox"/> | b. Must you use special equipment for participation (pads, braces, neck roll, etc.)? |
| | <input type="checkbox"/> | <input type="checkbox"/> | c. Has it been more than 5 years since your last tetanus booster shot? |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | a. Do you have any skin problems (acne, itching, rashes, etc.)? |
| | <input type="checkbox"/> | <input type="checkbox"/> | b. Have you had any bacterial or viral skin infections? |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | a. Have you ever had fainting, convulsions, seizures or severe dizziness? |
| | <input type="checkbox"/> | <input type="checkbox"/> | b. Do you have frequent severe headaches? |
| | <input type="checkbox"/> | <input type="checkbox"/> | c. Have you ever had a neck or head injury? |
| | <input type="checkbox"/> | <input type="checkbox"/> | d. Have you ever had a "stinger", "burner", or "pinched nerve"; or had numbness or tingling in your arms, hands, legs, or feet? |
| | <input type="checkbox"/> | <input type="checkbox"/> | e. Have you ever been "knocked out" or "passed out"? |
| | <input type="checkbox"/> | <input type="checkbox"/> | f. Have you ever had a concussion? If Yes, how many & when: _____ |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | Do you ever had heat exhaustion, heat stroke, heat cramps or similar heat-related problems? |
| 11. | <input type="checkbox"/> | <input type="checkbox"/> | a. Have you had any problem with your eyes or vision? If Yes, Check if you wear glasses, contacts or protective eyewear: <input type="checkbox"/> |
| | <input type="checkbox"/> | <input type="checkbox"/> | b. Do you wear any dental appliances such as a plate, retainer, or braces? If Yes, Check if you use a mouthguard for all sports: <input type="checkbox"/> |
| 12. | <input type="checkbox"/> | <input type="checkbox"/> | a. Are you worried about your weight? |
| | <input type="checkbox"/> | <input type="checkbox"/> | b. Do you rapidly lose or gain weight regularly to meet weight requirements for your sport or other reasons? |
| 13. | <input type="checkbox"/> | <input type="checkbox"/> | FEMALES ONLY: Have you had any menstrual concerns? |
| 14. | <input type="checkbox"/> | <input type="checkbox"/> | a. Has a physician ever denied or restricted your participation in sport(s)? |
| | <input type="checkbox"/> | <input type="checkbox"/> | b. Do you have any medical concerns about sports participation or are there other issues you would like to discuss with the doctor? |

Authorization forms for inhalers, oral medications, and other emergency medications are available online from the RSD Health Services website:
http://www.rentonschools.us/Departments/Health_Services/HealthForms
Please print and bring a copy of the medication authorization form(s) with you if needed.

Additional Details or other information: _____

RENTON SCHOOL DISTRICT ATHLETIC DEPARTMENT PHYSICAL EXAMINATION

Name: _____ Exam Date: _____
month/day/year

Height: _____ Weight: _____ Pulse: _____ Blood Pressure: _____

Visual Acuity: Left: 20/____ Right: 20/____ Peak Flow measurement for students with asthma (optional): _____

Physician: Please review the details of any positive answers from the reverse and confirm boxes on right are appropriately marked.

Normal		Abnormal		Findings and /or Details
<input type="checkbox"/>	1. Head	<input type="checkbox"/>		_____
<input type="checkbox"/>	2. Eyes (pupils), ENT	<input type="checkbox"/>		_____
<input type="checkbox"/>	3. Teeth	<input type="checkbox"/>		_____
<input type="checkbox"/>	4. Chest	<input type="checkbox"/>		_____
<input type="checkbox"/>	5. Lungs	<input type="checkbox"/>		_____
<input type="checkbox"/>	6. Heart	<input type="checkbox"/>		_____
<input type="checkbox"/>	7. Abdomen	<input type="checkbox"/>		_____
<input type="checkbox"/>	8. Genitalia	<input type="checkbox"/>		_____
<input type="checkbox"/>	9. Neurologic	<input type="checkbox"/>		_____
<input type="checkbox"/>	10. Skin	<input type="checkbox"/>		_____
<input type="checkbox"/>	11. Physical Maturity	<input type="checkbox"/>		_____
<input type="checkbox"/>	12. Spine, Back	<input type="checkbox"/>		_____
<input type="checkbox"/>	13. Upper extremities	<input type="checkbox"/>		_____
<input type="checkbox"/>	14. Lower extremities	<input type="checkbox"/>		_____

THIS EXAMINATION EXPIRES ON JULY 31ST (UNLESS IT IS PERFORMED IN JUNE OR JULY, IN WHICH CASE IT EXPIRES JULY 31ST OF NEXT YEAR).

ASSESSMENT: The signature below documents satisfactory examination of this student-athlete to include medical history (with special attention to cardiovascular / pulmonary risks and previous significant injury & rehabilitation / recovery), cardiopulmonary system, and appropriate sport-specific orthopedic screening.

- Full participation at the grade level indicated on the reverse
- Limited participation (describe limitations or restrictions below)

To be eligible to participate, the examiner must check one of these boxes.

Recommendations for or limitations of participation (disallowed sports, medications, equipment, bracing, taping, rehabilitation, etc.):

This student is eligible for participation as indicated above, but has the following condition(s) I classify as potentially life threatening:

Participation contraindicated (list reasons): _____

EXAMINER'S SIGNATURE: _____

DATE: _____

EXAMINER'S NAME
 (PRINTED or STAMP): _____

EXAMINER'S
 PHONE: (_____) _____

WIAA rules allow only a Medical Doctor (MD), Doctor of Osteopathy (DO), Advanced Registered Nurse Practitioner (ARNP), Physician Assistant (PAC), or Naturopathic Physician (NP / ND) to examine and qualify student-athletes as being fit for athletic participation. Contact information is required.