McLaren Flint
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 McLaren Flint 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: _____

_____

_____

_____

_____

I give permission to McLaren Flintto 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: ____/____, ____/____, ____/____

Vision: R 20/____ L 20/____ Corrected: Yes No 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: _____

_____

_____

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: _____

M-34579 (5/13)