

**Lincolnwood School District 74
Interscholastic Sports
Preparticipation Examination**

To be completed by athlete or parent

Name _____ Sport/Position _____
 Last First Middle

Address _____

City/State _____ Phone No. _____

Birthdate _____ Age _____ Class _____ Student ID No. _____

Parent's Name _____

Address _____

Phone No. _____

Person to contact in case of emergency _____

Phone No. _____

Family Doctor _____ City/State _____

Phone No. _____

Past Medical History	Yes	No	If Yes, please explain (what, where, when)
1. Presently taking medication (including birth control pills)	_____	_____	_____
2. Have you been diagnosed with asthma?	_____	_____	_____
3. Have you been prescribed by a physician to use any asthma medication?	_____	_____	_____
4. Do you have a current consent form to self administer the asthma medication on file with your school?	_____	_____	_____
5. Allergic to medicine, foods, bee stings?	_____	_____	_____
6. Wears any appliances — glasses, contact lenses?	_____	_____	_____
7. History of braces, chipped teeth, bridges?	_____	_____	_____
8. Has ongoing medical problem?	_____	_____	_____
9. Had serious or significant illness in past?	_____	_____	_____
10. Any past surgical operations, accidents, non-sports or	_____	_____	_____

Past Medical History

	Yes	No	If Yes, please explain (what, where, when)
related injuries?	_____	_____	_____
11. Any past injuries directly related to sports?	_____	_____	_____
12. Any hospitalization not explained above?	_____	_____	_____
13. Any known deformities (such as curvature of back, heart problems, one kidney, blindness in one eye, one testicle, etc.)?	_____	_____	_____
14. Any serious family illness (such as diabetes, bleeding disorders, etc.)?	_____	_____	_____
15. Heart			
Have you ever passed out during or after exercise?	_____	_____	_____
Have you ever been dizzy during or after exercise?	_____	_____	_____
Have you ever had chest pain during or after exercise?	_____	_____	_____
Do you get tired more quickly than your friends do during exercise?	_____	_____	_____
Have you ever had racing of your heart or skipped heartbeats?	_____	_____	_____
Have you had high blood pressure or high cholesterol?	_____	_____	_____
Have you ever been told you have a heart murmur?	_____	_____	_____
Has any family member or relative died of heart problems or of sudden death before age 50?	_____	_____	_____
Have you had a severe viral infection (for example myocarditis or mononucleosis) within the last month?	_____	_____	_____
Has a physician ever denied or restricted your participation in sports for any heart problems?	_____	_____	_____
Has anyone in your family had a heart attack before the age of 50?	_____	_____	_____
16. Head and Nerve			
Have you ever had a head injury or concussion?	_____	_____	_____
Have you ever been knocked out, become unconscious, or lost your memory?	_____	_____	_____
Have you ever had a seizure?	_____	_____	_____
Do you have frequent or severe headaches?	_____	_____	_____
Have you ever had numbness or tingling in your arms, hands, legs or feet?	_____	_____	_____
Have you ever had a stinger, burner or pinched nerve?	_____	_____	_____
17. Last tetanus shot?	Date	_____	_____
18. Last eye exam?	Date	_____	_____
19. Last menstrual period (if women)	Date	_____	_____

Personal Habits

Yes

No

- | | | | |
|----|--|-------|-------|
| 1. | Smoking/smokeless tobacco | _____ | _____ |
| 2. | Alcohol/non-medical drugs: marijuana,
cocaine, etc. | _____ | _____ |
| 3. | Steroids | _____ | _____ |
| 4. | Eating Disorders – weight loss or gain? | _____ | _____ |

Review of systems (Please check if you have any problems with any of the following areas of your body.)

- | | | |
|----------------------|------------------------------------|------------------------------|
| _____ Skin | _____ Lungs | _____ Shoulders, Arms, Hands |
| _____ Head | _____ Heart | _____ Hips, Legs, Feet |
| _____ Eyes | _____ Abdomen | _____ Muscles — Strength, |
| _____ Ears | _____ Back | _____ Feeling |
| _____ Nose | _____ Urination, Bowel control | _____ Mental, Emotional |
| _____ Mouth/Throat | _____ Genital (including menstrual | _____ Fatigue |
| _____ Nutrition, | _____ for women) | _____ Other: What? |
| _____ Weight Control | | _____ |
| _____ Neck | | _____ |

I certify that the above information is correct to the best of my knowledge.

Student Signature _____

Parent/Guardian Signature _____

Both Student and Parent/Guardian Signatures are Mandatory

To be completed by physician

Physical Examination

Height _____ Weight _____ Blood Pressure _____
Pulse: resting _____ 15 hops _____ after 2 minutes _____
Visual Acuity: _____ Eyes (R) 20/ _____ w/o glasses _____ (L) 20/ _____ w/glasses _____

Other Testing

Normal

Abnormal Findings

1. General	_____	_____
2. Skin	_____	_____
3. HEENT	_____	_____
4. Teeth (Dental Exam)	_____	_____
5. Neck	_____	_____
6. Lungs	_____	_____
7. Heart (Sit and Stand)	_____	_____
8. Abdomen	_____	_____
9. Genitalia	_____	_____
10. Musculoskeletal	_____	_____
Neck	_____	_____
Shoulder/Arm	_____	_____
Elbow/Forearm	_____	_____
Wrist/Hand	_____	_____
Back	_____	_____
Hip/Thigh	_____	_____
Knee	_____	_____
Shin/Calf	_____	_____
Ankle/Leg	_____	_____
Foot	_____	_____
11. Peripheral Pulses	_____	_____
12. Neurologic	_____	_____
13. Mental Status	_____	_____
14. Marfan Screen	_____	_____
15. 12 lead electro- cardiogram (EKG)	_____	_____

Other Tests (optional)

_____ Auditory	_____ U/V	_____ Chest X-Ray
_____ % Body Fat	_____ Drug Screen	_____ Tanner Stage
_____ Hgb/Hct	_____ SMAC	_____

On the basis of the examination of this day, I approve this child's participation in interscholastic sports for one year.

Yes _____ No _____ Limited _____

Additional Comments:

Examination Date _____ Physician's Name _____

Physician's Tel. # _____ Physician's Signature _____