DUVAL COUNTY SCHOOLS PREPARTICIPATION ATHLETIC SCREENING FORM • SIDE I

Name: ________________________ Sex: □F □M Age: _______ Date of Birth ________/________/__________
Grade: _____ School: ______________________ Sport(s): ______________________________
Address: ____
Personal Physician: ______________________ Physicians Phone: ______________________
In case of emergency: Name: ______________________ Relationship: _________________ Phone: _______________

For Physician use only
(Circle One)
New Interval 1 Interval 2
Date: ____________

SIDE I OF THIS FORM MUST BE COMPLETELY FILLED OUT AND SIGNED BY BOTH THE ATHLETE AND THE PARENT/GUARDIAN
CIRCLE QUESTIONS THAT YOU DO NOT KNOW THE ANSWERS TO

#	Yes	No	◄ CHECK ONE EXPLAIN YES ANSWERS ON THE BACK
1			Have you had a medical illness or injury since your last check up or sports physical?
2			Do you have any ongoing or chronic diseases?
3			Have you ever been hospitalized overnight?
4			Have you ever had surgery?
5			Are you currently using prescription or non prescription (over the counter) medications, pills or inhalers?
6			Have you ever taken supplements or vitamins to help you gain or loose weight or improve your performance?
7			Do you have allergies? (foods, insects or medications)
8			Have you ever had a rash or hives develop during or after exercise?
			Have you ever……..
9			passed out during or after exercise?
10			been dizzy during or after exercise?
11			had chest pain during or after exercise?
12			Do you tire more quickly than your friends during exercise?
			Have you ever had?.....
13			Racing of your heart or skipped heartbeats?
14			High blood pressure/ high cholesterol?
15			been told you have a heart murmur?
16			any family member or relative die of a heart attack or sudden death before age 50?
17			Are there any children in your family with heart problems?
18			Have any children in your family passed out or had a seizure as a result of a heart problem?
19			Have you had a severe viral infection(myocarditis or mononucleosis)?
20			Has a physician ever denied or restricted your participation in sports for any heart problems?
21			Do you have current skin problems (itching, rashes, acne, warts, fungus or blisters)
			Have you ever had
22			a head injury or concussion?
23			been knocked out, become unconscious, or lost your memory?
24			a seizure?
25			numbness or tingling in your arms, hands, legs or feet?

#	Yes	No	◄ CHECK ONE EXPLAIN YES ANSWERS ON THE BACK
26			a stinger, burner, or pinched nerve?
27			frequent or severe headaches?
28			Have you ever become ill from exercising in the heat?
29			Do you cough, wheeze or have trouble breathing during or after activity?
30			Do you have asthma?
31			Do you have seasonal allergies that require medical treatment?
32			Do you use any special protective or correctional equipment or devices that aren't usually used for your sport or position?(knee braces, neck roll, foot orthotics, retainer (teeth) hearing aid)
33			Have you had any problems with your eyes or vision?
34			Do you wear glasses, contacts or protective eyewear?
35			Have you ever had a sprain, strain, or swelling after injury?
36			Have you broken or fractured any bones or dislocated any joints?
37			Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? **See Checklist on Side II**
38			Do you want to weigh more or less than you do now?
39			Do you lose weight regularly to meet requirements of your sport?
40			Do you feel stressed?

Record the datesof your most recent immunizations:
Tetanus ___________ **Measles** ___________
Hepatitis B ________ **Chicken Pox** __________

Females Only

#	Yes	No	
41			When was your first menstrual period?
			Age _______________or Date____________________ Not yet: □
42			When was you most recent period?
			Started:____________________________________
43			How much time do you usually have from the start of one period to the start of another? ___________________________
44			How many periods have you had in the past year? _____________
45			What was the longest time between periods in the last year? ________________
46			Do you have questions or concerns regarding your menstrual cycle?
47			Do you have any questions or concerns you wish to ask the doctor?

SIGN **I HEREBY STATE, THAT TO THE BEST OF MY KNOWLEDGE, MY ANSWERS TO THE ABOVE QUESTIONS ARE COMPLETE AND CORRECT.**

► ATHLETE SIGNATURE ______________________________ PARENT SIGNATURE: ______________________________

PARENT OR GUARDIAN READ AND SIGN:I certify that the information above is true and I consider him/her capable of participating in athletics. I hereby give my consentfor the above named student: (1) to represent his/her school in athletic activities, except for those exceptions cited by the examining physician, provided that such athletic activities are approved by the School Board /FHSAA.(2) to accompany the team of which he/she is a member on any of its local or out of town trips. I further authorize the school to obtain any emergency medical care that may become necessary for the student in the course of such athletic activities or such travel and understand the cost of such treatment will be at my expense. I also agree not to hold the School Board or anyone acting in its behalf or the FHSAA responsible for any injury occurring to the above named student in the course of such athletic activities or such travel. I also grant permission to the Duval County School Board to release any and all athletic injury information relating to the above named student to the Sports Medicine Program Injury Registry. The Preparticipation Athletic Screening performed today is limited and designed to identify common conditions or infirmities that would limit or prevent a student from participating in athletic activities. This examination is NOT intended to be comprehensive and may not detect some types of latent or hidden medical conditions. ALL athletes should receive routine comprehensive medical examinations and prompt treatment for illnesses and injuries.

► **I DO __________ I DO NOT _________ Wish to purchase the school Student Accident or Football Insurance.**

SIGN ***I have read and understand the above statements.***

► **Signature of Parent / Guardian**: ______________________________ Date: _______/_______/_________

Any YES answers should be explained on Side II

School Year 2008 - 2009

► **Explain YES Answers Here**

Question 37: □ Head □ Neck □ Shoulder □ Arm □ Elbow □ Wrist □ Hand □ Finger □ Back □Chest □Hip □ Thigh □ Knee □ Shin/Calf □ Ankle □ Foot
Please Describe:

Duval County Schools Preparticipation Screening Form ● Side II

Physical Examination:

Name: ______________________ Date of Birth: ______/______/______

Height: ________ Weight: ________ %Body Fat ________ Pulse ________ BP: ______/______ (______/______)

Vision: R 20/ L 20/ Corrected Y N Contacts / Glasses Pupils: Equal Unequal Other:

	Normal	Abnormal	Initials
Medical			
Appearance			
EENT			
Lymph Nodes			
Heart			
Appearance			
Pulses			
Lungs			
Abdomen			
Genitals			
Skin			
Musculoskeletal			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			
Neurological			

Clearance

□ Cleared JSMP 1325 San Marco Blvd; suite 301 Jacksonville, FL 32207● 904-202-5219 Date: _____/______/______

Physicians Name:

________________________ Printed ________________________ Signature

□ Not Cleared for: Sport(s): ________________________

Reason: ________________________

Recommendation: ________________________

Physicians Name:

________________________ Printed ________________________ Signature

Physician / Follow up

Diagnosis: ________________________ DATE: ________________

□ **May Participate with NO restrictions** □ **May Participate, but with restrictions** □ **May NOT participate**

Limitations: ________________________

Physicians Name:

________________________ Printed ________________________ Signature

Address: ________________________ Phone: ________________

2008-2009