Sports Participation Questionnaire

I. Name of Student: ______________________________ Grade: ________
Last / First / Middle Initial

Date of Birth ______________________ Sex: ☐ Male ☐ Female

Sport (s) ____

II. Please answer question A-D YES or NO. At any time in the past has he or she had any operations involving:

A. Head, eyes, ears, nose, throat ---------------------------- ☐ YES ☐ NO
B. Chest, heart, lungs ---------------------------- ☐ YES ☐ NO
C. Back, abdomen ---------------------------- ☐ YES ☐ NO
D. Arms, legs ---------------------------- ☐ YES ☐ NO

If the answer is YES to any of the question A-D, fill in the information on this chart:

Operation	Date of Operation	Doctor who Operated	Hospital	City and State of Hospital

III. Please answer question A-D YES or NO. At any time in the past has he or she had any injuries to:

A. Head, eyes, ears, nose, throat ---------------------------- ☐ YES ☐ NO
B. Chest, heart, lungs ---------------------------- ☐ YES ☐ NO
C. Back, abdomen ---------------------------- ☐ YES ☐ NO
D. Arms, legs ---------------------------- ☐ YES ☐ NO

If the answer is YES to any of the questions A-D, fill in the chart below:

Injury	Date (Approx)	Doctor who treated it(If not seen by a doctor, make a line in the space)

IV. Please answer question A-D YES or NO. At any time in the past has this student had any major illnesses, acute or chronic, involving:

A. Head, eyes, ears, nose, throat ---------------------------- ☐ YES ☐ NO
B. Chest, heart, lungs ---------------------------- ☐ YES ☐ NO
C. Back, abdomen, stomach, intestines---------------------------- ☐ YES ☐ NO
D. Arms, hands, legs, feet ---------------------------- ☐ YES ☐ NO
E. Skin, joints, bones or muscles ---------------------------- ☐ YES ☐ NO

If the answer is YES to any of the question A-E, fill in the information on this chart:

Illness	Date (Approx.)	Doctor who treated illness-Still being treated- YES or NO

V. Please Answer all of the following question YES or NO. If YES, please write any additional information you have.

A. Is this student supposed to be taking any medications at this time?----- ☐ YES ☐ NO
If yes: 1. What medicines? ______________________________
2. Is he/she actually taking this medicine---------------------------- ☐ YES ☐ NO

B. Is this student allergic to any medicine ☐ YES ☐ NO
If YES, which medicines ________________

C. Has he or she had tetanus vaccination ☐ YES ☐ NO
If YES, give the year of last vaccination ________________

PLEASE ANWER THE FOLLOWING QUESTIONS:

Question	YES	NO
Any hearing loss or repeated infections?	☐ YES	☐ NO
Any severe or repeated skin infections?	☐ YES	☐ NO
Any blindness, color blindness, double vision, blurred vision, glasses or contacts?	☐ YES	☐ NO
Any asthma, wheezing, chronic cough, unusual or uncomfortable shortness of breath?	☐ YES	☐ NO
Any chest pain or chest discomfort?	☐ YES	☐ NO
Any history of irregular or unusually fast heart rate, high blood pressure, passing out, heart murmur, turning blue, rheumatic fever?	☐ YES	☐ NO
Any blood from the rectum, hepatitis, jaundice (turning yellow), frequent abdominal pains?	☐ YES	☐ NO
Any kidney infections, kidney stones, or repeated bladder infections?	☐ YES	☐ NO
Any seizures or convulsions?	☐ YES	☐ NO
Any swelling, pain or stiffness in joints?	☐ YES	☐ NO
Any deformity or arm or leg?	☐ YES	☐ NO
Any hernia or rupture?	☐ YES	☐ NO
Any anemia or unusual bleeding?	☐ YES	☐ NO
Any history of abnormally high or low blood sugar, diabetes, thyroid problems or other endocrine or gland problem?	☐ YES	☐ NO
Any other health problems or concerns?	☐ YES	☐ NO
Any back or neck pain?	☐ YES	☐ NO
Do you have dentures or braces?	☐ YES	☐ NO

The information I have provided is correct to the best of my knowledge. I hereby give permission for (student name) ________________ to have a medical examination, as arranged by the school before he or she starts sports participation. If approved by the examining doctor, I give permission for (student name) ________________ to take part in any of the following sports except ________________.

List of Sports ________________

I am the legal parent or guardian of this student. ________________
(Parent or Legal Guardian Signature)

____
(Date)

☐ ***Family cardiac history reviewed – required for Dominick Murray Sudden Cardiac Arrest Prevention Act**

Height ______ Weight ______ BP ______ Scoliosis ______ BMI ______

____
(School Physician)

____
(Date)