

South Carolina Independent School Association Pre-Participation Health Assessment

Name _____ Date of Birth _____

Address _____

Person to Notify for _____

Emergency _____

Their Telephone Number _____

Physician _____ Telephone number _____

History to be completed by student and parents

Yes No (Check One)

1. ___ ___ Did your grandparents, parents, brothers, sisters, under the age of 50 have heart problems or high blood pressure?

Have You Ever Had Or Do You Presently Have:

2. ___ ___ Heart murmur, high blood pressure, extra heart beats, heart abnormality?

3. ___ ___ The need for using medications? Name: _____

4. ___ ___ Concussion or problem "passing out"?

5. ___ ___ Medicine allergy? Name: _____

6. ___ ___ Any illness, condition, or injury that lasted longer than a week? Name: _____

7. ___ ___ Hospitalization or surgery? Why? _____

8. ___ ___ Dental appliance?

9. ___ ___ Contacts or eye glasses?

10. ___ ___ Need to stop while running around a 1/4 mile track twice?

11. ___ ___ An illness or injury that caused you to miss a game or practice? _____

12. ___ ___ Congenital absence or loss of function of one organ (eye, ear...)?

13. ___ ___ Frequent headaches?

14. ___ ___ Asthma?

15. ___ ___ Convulsions (seizures)? If yes, type: _____ How many? _____

16. ___ ___ Neck or Spine injury? (If yes, please explain) _____

17. ___ ___ Broken bones? _____

18. ___ ___ Sprains or dislocations? _____

19. ___ ___ Date of last tetanus shot? _____

20. ___ ___ Females: Have you had a period in the last six months?

21. ___ ___ Females: Do menstrual cramps keep you from your regular activity?

Parent's Permission for Son or Daughter to Participate in Athletics

As the parent or legal guardian of _____, I give my consent for their participation in athletic and the evaluation for that participation. I do not hold the school responsible in any way. I also grant permission for treatment deemed necessary for a condition arising during participation in these activities, including medical or surgical treatment recommended by a medical doctor, I understand that every effort will be made to contact me prior to treatment. I certify that the medical history is accurate to the best of my knowledge.

Parent's Signature _____

Date _____

South Carolina Independent School Association
Medical Examination Form

Please Print

Last Name First Name Middle Initial Date of Birth
Gender: M F SSN _____ Age: ____ Grade: _____

PHYSICAL EXAM - To be completed by Physician

Height _____ Weight _____ Pulse _____ Blood Pressure _____

Normal Abnormal Findings Initials

1. Eyes (vision) _____
2. Ears, Nose, Throat _____
3. Mouth & Teeth _____
4. Neck _____
5. Cardiovascular _____
6. Abdomen _____
7. Chest & Lungs _____
8. Skin _____
9. Genitalia-hernia _____
(male)
10. Musculoskeletal: ROM, strength, etc. _____
 - Neck _____
 - Spine _____
 - Shoulders _____
 - Arms/hands _____
 - Hips _____
 - Thighs _____
 - Knees _____
 - Ankles _____
11. Neuromuscular _____

Your general assessment of health (limitation, referrals, etc.) _____

Notice to parents: urinalysis and hematocrit/hemoglobin are optional. Parents should consider both tests in order to provide additional medical information.

I certify that I have examined this athlete on this date and found him/her medically qualified to participate in sports. I also certify that I am a licensed physician.

Physician's Signature: _____

Date: _____

Physician's Address: _____
