

WEST MICHIGAN CHRISTIAN ATHLETIC ASSOCIATION, INC.

PREPARTICIPATION PHYSICAL FORM FOR ATHLETIC ACTIVITIES

Personal Information (PLEASE PRINT) *ALL ITEMS IN BOLD PRINT MUST BE COMPLETED!!

Name _____ Sex {circle} **M** **F** Grade {circle} **9** **10** **11** **12**
 Date of Birth {Month/Day/Year} ____/____/____ Social Security Number of Student _____ - _____ - _____
 Mailing Address _____ City _____ Zip Code _____
 Parent/Guardian _____ Home Phone _____ Work Phone _____
 Person to Notify in an Emergency _____ Phone _____ Alternate _____
 Family Doctor _____ Phone _____ Alternate _____
 Is this student covered by private health care/medical insurance and/or Medicaid? ___ Yes ___ No Medicaid #: _____
 Name of private healthcare/medical insurance provider: _____
 Policy Holder's Name: _____ Social Security #: _____ - _____ - _____
 Group Name: _____ Group #: _____ Policy #: _____

Sports you plan to play {√ all that apply} ___ Football ___ Baseball ___ Softball ___ Volleyball ___ Cheerleading

Medical History (Answer ALL questions by checking the YES or NO boxes. Explain ALL "Yes" answers in the space below!!)

GENERAL MEDICAL HISTORY:		YES	NO
1.	HAVE YOU HAD ANY MEDICAL PROBLEM OR PHYSICAL INJURY SINCE YOUR LAST PHYSICAL EXAM?	ﻗﺎ	ﻗﺎ
2.	Do you have asthma?.....	ﻗﺎ	ﻗﺎ
3.	Do you have diabetes?	ﻗﺎ	ﻗﺎ
4.	Do you have high blood pressure?	ﻗﺎ	ﻗﺎ
5.	Do you have seizures?.....	ﻗﺎ	ﻗﺎ
6.	Do you have sickle cell trait?	ﻗﺎ	ﻗﺎ
7.	Have you have any other major medical problem?	ﻗﺎ	ﻗﺎ
8.	Have you ever been hospitalized or had surgery?	ﻗﺎ	ﻗﺎ
9.	Do you cough, wheeze, or have trouble breathing when exercising?	ﻗﺎ	ﻗﺎ
10.	Do you use an inhaler?	ﻗﺎ	ﻗﺎ
11.	Do you have a single organ (testicle or kidney)?	ﻗﺎ	ﻗﺎ
12.	Are you currently taking any medicines or do you take any medicines on a regular basis (prescription or over-the-counter)?	ﻗﺎ	ﻗﺎ
13.	Have you ever taken any supplements or vitamins to help with weight loss, weight gain, or to improve performance?	ﻗﺎ	ﻗﺎ
14.	Do you have any allergies (seasonal, insects, food, or medicines)?	ﻗﺎ	ﻗﺎ
15.	Have you ever had a rash or hives develop during or after exercise?	ﻗﺎ	ﻗﺎ
16.	Do you have any skin problems other than acne?	ﻗﺎ	ﻗﺎ
17.	Have you ever had a head injury, been knocked out, lost your memory, had your "bell rung", or a concussion?	ﻗﺎ	ﻗﺎ
18.	Have you ever had numbness or tingling in your arms, hands, legs, or feet?	ﻗﺎ	ﻗﺎ
19.	Have you ever had a "stinger", "burner", or pinched nerve? ...	ﻗﺎ	ﻗﺎ
20.	Have you ever become ill from exercising in the heat?	ﻗﺎ	ﻗﺎ
21.	Have you had mononucleosis or any significant illness in the last 60 days?	ﻗﺎ	ﻗﺎ
22.	Do you have trouble with your eyes/vision/wear glasses or contacts?	ﻗﺎ	ﻗﺎ
23.	Do you have trouble with your hearing/wear hearing aids?	ﻗﺎ	ﻗﺎ
24.	Do you want to weigh more or less than you do now?	ﻗﺎ	ﻗﺎ
25.	Do you lose weight regularly to meet weight requirements for your sport or other reasons?	ﻗﺎ	ﻗﺎ
26.	Do you feel stressed out, overly tired, or depressed?	ﻗﺎ	ﻗﺎ
27.	Are there any other issues you would like to discuss with the doctor?.....	ﻗﺎ	ﻗﺎ

FEMALES ONLY:		YES	NO
28.	Are your periods regular (every month)?.....	ﻗﺎ	ﻗﺎ
29.	Are your periods heavy?.....	ﻗﺎ	ﻗﺎ
30.	When was your first period? Month _____ Year _____		
31.	When was your last period? Month _____ Year _____		
CARDIAC HISTORY:		YES	NO
1.	Have you ever passed out during or after exercise?	ﻗﺎ	ﻗﺎ
2.	Have you ever been dizzy during or after exercise?	ﻗﺎ	ﻗﺎ
3.	Have you ever had chest pain or chest pressure during or after exercise?	ﻗﺎ	ﻗﺎ
4.	Do you tire easily or more quickly than your friends during exercise?	ﻗﺎ	ﻗﺎ
5.	Have you ever had racing of your heart or skipped heartbeats?	ﻗﺎ	ﻗﺎ
6.	Have you ever been told you had a heart murmur?	ﻗﺎ	ﻗﺎ
7.	Have you ever been told you had an enlarged heart?	ﻗﺎ	ﻗﺎ
8.	Has any member of your family: - died of heart problems or sudden death before age 50?.....	ﻗﺎ	ﻗﺎ
	- been told they had a serious heart problem before age 50?....	ﻗﺎ	ﻗﺎ
	- been told they had Marfan's Syndrome?.....	ﻗﺎ	ﻗﺎ
9.	Has a physician ever denied or restricted your participation in sports?.....	ﻗﺎ	ﻗﺎ
ORTHOPAEDIC HISTORY:			
1.	Have you ever broken or fractured any bones?.....	ﻗﺎ	ﻗﺎ
2.	Have you ever dislocated or partially dislocated any joint?.....	ﻗﺎ	ﻗﺎ
3.	Have you had any problems related to your: - neck, spine, or back?.....	ﻗﺎ	ﻗﺎ
	- shoulders?.....	ﻗﺎ	ﻗﺎ
	- elbows?.....	ﻗﺎ	ﻗﺎ
	-wrists, hands, or fingers?.....	ﻗﺎ	ﻗﺎ
	- hips?.....	ﻗﺎ	ﻗﺎ
	- knees?.....	ﻗﺎ	ﻗﺎ
	- ankles, feet, or toes?.....	ﻗﺎ	ﻗﺎ
	- other?.....	ﻗﺎ	ﻗﺎ

Please explain YES answers from above in this space:

Signature of parent/guardian: _____ Date signed: _____

**A photocopy or facsimile of this document shall be considered the same as the original document.

Pre-participation Physical Examination

Date: _____

Physical Examination

Name: _____ Age: _____ Date of Birth: ____/____/____

LIMITED	Height _____ Weight _____ BP _____/_____/_____ Pulse _____ Respiration _____			
	Vision R 20/____ L 20/____ Corrected (CIRCLE): Yes No If yes, with? (CIRCLE) Glasses Contacts			
		NORMAL	ABNORMAL FINDINGS	INITIALS
	CARDIPULMONARY			
	PULSES			
	HEART			
	LUNGS			
	SKIN			
	ABDOMINAL			
	GENITALIA			
COMPLETE	MUSCULOSKELETAL			
		NORMAL	ABNORMAL FINDINGS	INITIALS
	NECK			
	SHOULDERS			
	ELBOWS			
	WRISTS			
	HANDS			
	BACK/SPINE			
	HIP/PELVIS			
	KNEES			
	ANKLES			
	FEET			
	DENTAL EXAM			
		NORMAL	ABNORMAL FINDINGS	INITIALS
GUMS AND TONGUE				
TEETH				
TMJ JOINT				

Clearance (check one): CLEARED Cleared *after* completing evaluation/treatment for: _____
 NOT CLEARED for sport/activity (list) _____
 NOT CLEARED FOR ANY SPORTS PARTICIPATION due to: _____

Other recommendations: _____

Name of Examining Physician: _____ Phone Number: _____

Signature of Examining Physician: _____ Date: _____