**SPORTS PRE-PARTICIPATION ASSESSMENT**

**Name____________________________**  
**Date of exam_____________________**

**Age_____ Grade______ ☐ Male ☐ Female**

This exam is for  
☐ school (name)  
☐ Pop Warner league sports  
☐ other (e.g. camp, boxing physicals) ____________________________

**Circle the sport(s) that you will be playing:**

1. Baseball  
2. Basketball  
3. Cheerleading  
4. Cross-country  
5. Field Hockey  
6. Football  
7. Golf  
8. Gymnastics  
9. Lacrosse  
10. Soccer  
11. Softball  
12. Swimming  
13. Track/Field  
14. Tennis  
15. Volleyball  
16. Water Polo  
17. Wrestling

1. Have you ever been *hospitalized* (overnight)?  
2. Are you currently taking medication?  
3. Do you have any *allergies* (medicines, bees)?  
4. Have you ever **passed out** during exercise?  
   (not from heat)
   Have you ever been *dizzy during exercise*?  
   (not from heat)
   Have you ever had *chest pain*?  
   Do you tire more quickly than your friends during exercise?  
   Have you ever had *high blood pressure*?  
   Have you ever been told you have a *heart murmur*?  
   Have you ever had racing of your heart or skipped beats?  
   Has anyone in your family died of heart problems or a sudden death before age 40?  
   Does anyone in your family have *Marfan's Syndrome*?

5. Have you ever had a *head injury*?  
6. Have you ever had a *broken bone*?  
7. Have you ever had *heat cramps*?  
8. Do you use special pads or braces?  

9. Have you ever been hospitalized (overnight)?  
   Have you ever had surgery?  
   Have you ever been *knocked out*?  
   Have you ever had a *seizure*?  
   Have you ever had a *burner/stinger* (pain from neck into arm)?

10. When was your last tetanus shot?   
11. When was your last tetanus shot?  
12. About your weight: Do you think that you are  
   ☐ just right?  
   ☐ too heavy/fat?  
   ☐ too light/thin?  
13. Do you like to drink milk products?  
   Yes ☐ No ☐

14. For females:  
   When was your first period and how old were you?  
   When was your last period?  
   Are your periods ☐ regular/monthly ☐ irregular/skip months

15. Please feel free to ask the doctor to address any questions/concerns that you may have.  
   [note: all discussions are kept confidential]

__I hereby give my consent for medical evaluation and declare that the information I provided is true and correct to the best of my knowledge.__

__________________________________________
Parent's signature

☐ I have reviewed above history.  
(Physician's initials)