



A Division of Metropolitan Hospital
 6807-D Cascade Road, SE, Grand Rapids, MI, 49546
 (616) 252-7900 or (616) 252-SPORT

**ATHLETE
 PREPARTICIPATION
 EXAMINATION**

TO BE COMPLETED BY PARENT/GUARDIAN OR 18-YEAR OLD

NAME LAST, FIRST		TODAY'S DATE		TIME
BIRTHDATE		AGE	SCHOOL	GRADE
MALE <input type="checkbox"/>	FEMALE <input type="checkbox"/>		SPORTS	
HOME ADDRESS		FATHER/GUARDIAN		PH (W)
		MOTHER/GUARDIAN		PH (W)
PH (H)	PH (C)		FAMILY INSURANCE	
FAMILY DR	PH	CONTRACT NUMBER		
SUBJECTIVE EVALUATION				
QUESTIONS		YES	NO	EXPLAIN IF "YES"
1. Have you had any prior LIMITATION placed on your SPORTS PARTICIPATION (<i>heart...</i>)?				
2. Have you had any ILLNESS/INJURY since your last sports physical or checkup?				
Do you have an ongoing chronic illness?				
Have you ever been HOSPITALIZED overnight?				
Have you had any SURGERIES?				
3. Are you presently taking any MEDICATION (<i>prescription, over the counter, inhalants</i>)?				
Have you ever taken vitamin/supplements for weight gain or performance improvement?				
4. Do you have ALLERGIES (<i>to medication, bees, etc.</i>)?				
Have you ever had a RASH or HIVES develop during or after exercise?				
5. Have you ever PASSED OUT during exercise or after?				
Have you ever been DIZZY during or after exercise?				
Have you ever had CHEST PAINS during or after exercise?				
Do you tire quicker than your friends during exercise?				
Have you been diagnosed with HIGH BLOOD PRESSURE or HIGH CHOLESTEROL?				
Have you ever been told you have a HEART MURMUR?				
Have you ever noticed any RACING OF YOUR HEART or IRREGULAR PULSE?				
Do you have a family history of HEART DISEASE?				
Have any of your family members died of heart problems or sudden death before turning 50?				
6. Do you COUGH, WHEEZE, or have TROUBLE BREATHING during or after exercise?				
Do you have SEASONAL ALLERGIES that require treatment?				
7. Have you ever had a HEAD INJURY or CONCUSSION?				
Have you ever been KNOCKED OUT or LOST YOUR MEMORY?				
Have you ever had a SEIZURE?				
Have you ever had a STINGER, BURNER or PINCHED NERVE (<i>numbness/tingling in hands/feet</i>)?				
8. Have you ever INJURED (<i>sprained, dislocated, fractured, etc.</i>) your : (<i>check POSITIVE, give details</i>)				
<input type="checkbox"/> Neck <input type="checkbox"/> Elbow <input type="checkbox"/> Thigh <input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Knee				
<input type="checkbox"/> Shoulder <input type="checkbox"/> Hand <input type="checkbox"/> Calf/Shin <input type="checkbox"/> Hip <input type="checkbox"/> Finger/Thumb <input type="checkbox"/> Foot				
9. Have you ever become ILL from exercising in the HEAT?				
10. Do you have any SKIN PROBLEMS (<i>itching, rashes, acne, warts, fungus</i>)?				
11. Have you ever HAD any of the following: (<i>check POSITIVE, give details</i>)				
<input type="checkbox"/> Hernia <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Diabetes <input type="checkbox"/> Asthma <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Tuberculosis				
<input type="checkbox"/> Hepatitis <input type="checkbox"/> Sickle cell anemia <input type="checkbox"/> Scoliosis <input type="checkbox"/> Blurred vision <input type="checkbox"/> Headaches <input type="checkbox"/> Absent spleen				
<input type="checkbox"/> Absent kidney <input type="checkbox"/> Absent eye <input type="checkbox"/> Stomach ulcers				
12. Do you wear GLASSES, protective eye wear or contact lenses?				
13. Do you use pads, braces or other protective or corrective equipment?				
14. Do you want to WEIGH MORE or LESS than you do now?				
Do you feel STRESSED OUT?				
15. Date of last VACCINE for	TETANUS	MEASLES	HEPATITIS B	CHICKEN POX
16. (<i>For Women</i>) When was your 1st menstrual period?		Most recent period?	How many periods have you had in the last year?	
How much time do you usually have from the start of one period to the start of another?			What was the longest time between periods?	
<p>I hereby state that, to the best of my knowledge, my answers above are complete & correct. My signature also indicates :</p> <p>1. My permission for the performance of the preparticipation evaluation. 2. Acceptance & compliance to district & MHSAA guidelines. 3. Consent to emergency medical care in the event school personnel are unable to contact me.</p> <p>4. Consent to disclosure of information otherwise protected by FERPA and HIPAA for the purpose of determining eligibility for interscholastic athletics to the MHSAA and school district.</p>				
SIGNATURE OF ATHLETE		SIGNATURE OF PARENT/GUARDIAN		DATE