

MOREHOUSE COLLEGE
STUDENT HEALTH SERVICES
STUDENT-ATHLETE PRE PARTICIPATION CHECKLIST

Name _____ Date _____
 Sport _____

Need Done

Height/Weight

Vital Signs

Urinalysis

Protein - neg pos

Glucose – neg pos

EKG

Physical Examination

 Cleared

 Not Cleared

Sickle Cell

 Cleared

 Not Cleared

Student needs referral to: Ortho Cardiologist Other _____

Student needs to follow-up with College physician in _____ days/_____ weeks

MOREHOUSE COLLEGE ATHLETIC TRAINING SERVICES
STUDENT-ATHLETE PRE PARTICIPATION FORM

This form must be completed prior to athletic participation. If any portion is incomplete, the athlete will be asked to finish completing this form.

Athlete: _____ Grad yr: _____ Sport: _____ Date: _____
 D.O.B. ____ / ____ / ____ MC ID# _____
 Cell Phone #: _____ Campus Box #: _____ Dorm: _____ Rm# _____
 Home Address: _____ Home Phone #(____) _____
 City, State , zip _____
 Allergies: _____

MEDICAL HISTORY

Circle Question Number 1 of questions for which the answer is unknown.

Circle Y for Yes or N for No

GENERAL QUESTIONS

1. Has a doctor ever denied or restricted your participation in sports for any heart problems or for any reason told you to give up sports?.....Y / N
2. Have you had a medical illness or injury since your last check up or sports physical?Y/N
3. Do you have an ongoing or chronic medical illness/condition (like diabetes, asthma, anemia, infections)?Y / N
4. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills or using an inhaler?Y/ N
 List: _____
5. Do you have allergies to medicines, pollens, foods, or stinging insects?.....Y/ N
6. Have you ever been hospitalized overnight?Y/ N
7. Have you ever had surgery?Y / N

HEART HEALTH QUESTIONS ABOUT YOU

8. Have you ever passed out or nearly passed out DURING exercise?.....Y/ N
9. Have you ever passed out or nearly passed out AFTER exercise?Y/ N
10. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?.....Y / N
11. Does your heart race or skip beats (irregular beats) during exercise?.....Y/ N
12. Has a doctor ever told you that you have? (circle):
 High blood pressure A heart murmur High cholesterol A heart infection Rheumatic fever
 Kawasaki's Disease
13. Has a doctor ever ordered a test for your heart? (for example, ECG/EKG, echocardiogram, stress test). Y / N
14. Do you get lightheaded, dizzy or feel more short of breath than expected during exercise?Y/ N
15. Have you ever been knocked out, become unconscious, or lost your memory?Y/N
16. Do you have frequent or severe headaches?Y/N
17. Have you ever had an unexplained seizure?Y/ N
18. Do you get more tired or short of breath more quickly than your friends during exercise?Y/ N

HEART HEALTH QUESTIONS ABOUT YOUR FAMILY

19. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including unexplained drowning, unexplained car accident, or sudden infant death syndrome)?Y/ N

20. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?.....Y / N
21. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?.Y/ N
22. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?.....Y/ N

BONE AND JOINT QUESTIONS

23. Have you ever had an injury, like a sprain, muscle or ligament tear or tendonitis that caused you to miss a practice or game?Y / N
24. Have you broken or fractured any bones or dislocated any joints?.....Y/ N
25. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?.....Y / N
26. Have you ever had a stress fracture?Y/ N
27. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism).....Y / N
28. Do you regularly use a brace, orthotics or other assistive device?Y/ N
29. Do you have a bone, muscle, or joint injury that bothers you?Y/ N
30. Do any of your joints become painful, swollen, feel warm, or look red?Y/ N
31. Do you have any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?Y/N

If yes, check appropriate box and explain below

- | | | |
|------------------------------------|----------------------------------|------------------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> Elbow | <input type="checkbox"/> Hip |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Forearm | <input type="checkbox"/> Thigh |
| <input type="checkbox"/> Back | <input type="checkbox"/> Wrist | <input type="checkbox"/> Knee |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Hand | <input type="checkbox"/> Shin/calf |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> Finger | <input type="checkbox"/> Ankle |
| <input type="checkbox"/> Upper arm | <input type="checkbox"/> Foot | |

32. Do you have any history of juvenile arthritis or connective tissue disease?.....Y/ N

MEDICAL QUESTIONS

33. Has a doctor ever told you that you have asthma or allergies?.....Y/ N
34. Do you cough, wheeze, experience chest tightness, or have difficulty breathing during or after exercise?Y/ N
35. Is there anyone in your family who has asthma?.....Y/ N
36. Have you ever used an inhaler or taken asthma medicine?.....Y/ N
37. Do you have seasonal allergies that require medical treatment?Y/N
38. Do you develop a rash or hives when you exercise?.....Y/ N
39. Were you born without or are you missing a kidney, an eye, a testicle (males), or any other organ?Y/ N
40. Do you have groin pain or a painful bulge or hernia in the groin area?Y/ N
41. Have you had infectious mononucleosis (mono) within the last month?Y/ N
42. Do you have any rashes, pressure sores, or other skin problems (for example itching, rashes, acne, warts, fungus, or blisters) ?Y /N
43. Have you ever had a rash or hives developing during or after exercise?Y/N
44. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? Y/N
45. Have you had a herpes or MRSA skin infection?.....Y/ N
46. Have you ever had a head injury or concussion?Y/ N
47. Have you ever had a stinger, burner, or pinched nerve?.....Y/N
48. Have you ever had a hit or blow to the head that caused confusion prolonged headache, or memory problems?Y / N
49. Do you have a history of seizure disorder?Y/ N
50. Do you have headaches with exercise?.....Y /N
51. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?Y/ N
52. Have you ever been unable to move your arms or legs after being hit or falling?Y/ N

EMERGENCY INFORMATION

Emergency Contact: _____ Relationship _____

Telephone: (H) _____ - _____ - _____ (W) _____ - _____ - _____ (C) _____ - _____ - _____

Personal Physician _____ Office Telephone _____ - _____ - _____

MEDICAL CLEARANCE

Pre participation Medical Clearance: All athletes must be medically cleared prior to the start of each sport he/she chooses to participate in. This process includes completing a physical examination by a physician verifying that the athlete is able to participate without restrictions and all immunizations are up to date. All athletes must complete the athletic training pre-participation examination to be eligible to participate in athletics.

RELEASE AND CONSENT TO PARTICIPATE

I wish to participate in the sport(s) _____ during the _____ academic year, I understand that this sport is an inherently dangerous activity and that there are genuine and serious risks to anyone who engages in this activity. I understand that the risks of this activity and of transportation to and from this activity include, without limitation, a full range of injuries, including catastrophic injury resulting in permanent paralysis, brain injury or death. I knowingly assume responsibility for any and all such risks and all such injuries. In furtherance thereof, and as a condition of my voluntary participation in this sport, I accept the risks of my participation in the sport and in any transportation connected therewith. I do hereby release, waive, forever discharge, quit and covenant to hold harmless, indemnify and not to sue Morehouse College, its governing board, officers, agents, employees, volunteers and any students acting as employees or volunteers (hereinafter all called the "Releases"), against any and all liability for any harm, injury, damage, claims, demands, actions, causes of action, costs and expenses of any nature that I may have or that may hereafter accrue to me or my parents (if signing below) or to any of my dependents or beneficiaries arising out of or related to any loss, damage or injury, including but not limited to personal injury, pain, physical and emotional suffering and death, that may be sustained by me or by any property belonging to me or to any of my dependents or beneficiaries, whether caused by the negligence or carelessness.

I do not know of any existing physical or additional health reason that would preclude participation in sports. I certify that the answers to the above questions are true and accurate and I approve participation in athletic activities. I consent to be examined during the pre-participation examinations which includes, blood pressure, pulse, height, weight, and orthopedic examination.

STATEMENT OF CONFIDENTIALITY AND AUTHORIZATION TO RELEASE

A complete history and medical record is maintained on each athlete that participates in athletic programs at Morehouse College. All medical information is kept confidential and access is restricted to Student Health Center staff members responsible for your health care. Medical information will not be released without a signed authorization of release indicating what specific information is to be released, and who is to receive the information.

Signature of Student Athlete

Date

MEDICAL EXAM

Height _____ Weight _____ BMI (optional) _____ % Body fat (optional) _____ Arm Span _____

Pulse _____ BP _____ / _____ (_____ / _____)

Vision: R 20/____ L 20/____ Corrected: Y / N Contacts: Y / N Pupils: Equal _____ Unequal _____

Exam	Normal	Abnormal Notes	Initials*
Appearance	Y / N		
Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)	Y / N		
HEENT	Y / N		
Eyes/Ears/Nose/Throat	Y / N		
Fundoscopy	Y / N		
Pupils	Equal / Unequal		
Hearing	Y / N		
Lymph Nodes			
Cardiovascular	Y / N		
Murmurs (auscultation standing, supine, +/- Valsalva)	Y / N		
PMI location			
Pulses (simultaneous femoral & radial)	Y / N		
Heart			
Lungs	Y / N		
Abdomen	Y / N		
Genitourinary (Male)	Y / N		
Hernia	Y / N		
Genitalia (Males Only)			
Tanner Staging (optional)	I II III IV V		
Skin (HSV, MRSA, Tinea corporis)	Y / N		
Musculoskeletal			
Neck	Y / N		
Back	Y / N		
Shoulder/Arm	Y / N		
Elbow/Forearm	Y / N		
Wrist/Hand/Fingers	Y / N		
Hip/Thigh	Y / N		
Knee	Y / N		
Leg/Ankle	Y / N		
Foot/Toes	Y / N		
Functional (Duck Walk/Single Leg Hop)	Y / N		
EKG		<i>Other Lab</i>	
Urinalysis			
Sickle Cell Status: <input type="checkbox"/> negative <input type="checkbox"/> trait <input type="checkbox"/> positive			

Notes: _____

LICENSED MEDICAL PROFESSIONAL'S ATHLETIC PARTICIPATION CLEARANCE

 FULL & UNLIMITED PARTICIPATION

 LIMITED PARTICIPATION - May **NOT** participate in the following (checked):

- Baseball
- Basketball
- Baseball
- Bowling
- Cross Country
- Football
- Golf
- Soccer
- Softball
- Swimming
- Tennis
- Track
- Volleyball
- Wrestling

 CLEARANCE PENDING DOCUMENTED FOLLOW UP OF:

 NOT CLEARED FOR ATHLETIC PARTICIPATION DUE TO:

Comments regarding abnormal findings: _____

PLAN:

Immunizations:

- Up-to-Date
- Consider Influenza vaccination (Asthma, winter athletes)
- Immunization(s) needed: _____

Health Maintenance:

- Lifestyle, health, and safety counseling
- Discussed dental care and mouth guard use
- Discussed Lead exposure – (Testing indicated / not indicated)
- Discussed TB exposure

Physician's name (Printed)

Date

Physician's Signature

Phone