Pre-participation Physical Evaluation
Our Lady of Mount Carmel

Date of Exam: _____ Sport(s): _____

Name: _____ Sex: ___ Age: ___ Date of Birth: _____

Address: _____

Grade: _____ Personal physician: _____ Phone: _____

Explain "Yes" answers below.
Circle questions you don't know the answers to.

	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have an ongoing medical condition (like diabetes or asthma)?		
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?		
4. Do you have allergies to medicines, pollens, foods, or stinging insects?		
5. Have you ever passed out or nearly passed out DURING exercise?		
6. Have you ever passed out or nearly passed out AFTER exercise?		
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?		
8. Does your heart race or skip beats during exercise?		
9. Has a doctor ever told you that you have (check all that apply): High blood pressure / A heart murmur / High cholesterol / A heart infection		
10. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)		
11. Has anyone in your family died for no apparent reason?		
12. Does anyone in your family have a heart problem?		
13. Has any family member or relative died of heart problems or of sudden death before age 50?		
14. Does anyone in your family have Marfan syndrome?		
15. Have you ever spent the night in a hospital?		
16. Have you ever had surgery?		
17. Have you ever had an injury, like a sprain, muscle or ligament tear or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below:		
18. Have you had any broken or fractured bones, or dislocated joints? If yes, circle below:		
19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:		

Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand/ fingers	Chest
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/toes

20. Have you ever had a stress fracture?		
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?		
22. Do you regularly use a brace or assistive device?		
23. Has a doctor ever told you that you have asthma or allergies?		
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
25. Is there anyone in your family who has asthma?		
26. Have you ever used an inhaler or taken asthma medicine?		
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?		
28. Have you had infectious mononucleosis (mono) within the last month?		
29. Do you have any rashes, pressure sores, or other skin problems?		
30. Have you had a herpes skin infection?		
31. Have you ever had a head injury or concussion?		
32. Have you been hit in the head and been confused or lost your memory?		
33. Have you ever had a seizure?		
34. Do you have headaches with exercise?		
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
36. Have you ever been unable to move your arms or legs after being hit or falling?		
37. When exercising in the heat, do you have severe muscle cramps or become ill?		
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?		
39. Have you had any problems with your eyes or vision?		
40. Do you wear glasses or contact lenses?		
41. Do you wear protective eyewear, such as goggles or a face shield?		
42. Are you happy with your weight?		
43. Are you trying to gain or lose weight?		
44. Has anyone recommended you change your weight or eating habits?		
45. Do you limit or carefully control what you eat?		
46. Do you have any concerns that you would like to discuss with a doctor?		

FEMALES ONLY

47. Have you ever had a menstrual period?		
48. How old were you when you had your first menstrual period? _____		
49. How many periods have you had in the last year? _____		

Explain "Yes" answers here: _____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

OLMC PRE-PARTICIPATION PHYSICAL EVALUATION

Name:_____ **Birthdate:**_____

Height:_____ **Weight:**_____ **%Body fat (optional):**_____ **Pulse:**_____

BP:____/____ **Vision: R 20/**_____ **L20/**_____ **Corrected: Y N** **Pupils: Equal**_____ **Unequal**____

Risk behaviors discussed: Y N (diet, weight, driving, drugs, alcohol, sexuality, safety, stress)

	Normal	Abnormal findings	Initials
MEDICAL			
Appearance			
Eyes /ears /nose /throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males)*			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

*Multiple-examiner set-up only *Having 3rd party present is recommended for the genitourinary exam

Notes

lease choose one of the following four (4) options:

Cleared without restriction: _____

Cleared, with recommendations for further evaluation or treatment for:_____

*Not Cleared, but needs additional evaluation by (whom):_____

Not Cleared for either: _____ All sports: _____ Certain sports:_____

:ason:_____

:ase note any necessary equipment, medications, or restrictions for cleared athlete to play or practice.

this signature, I hereby state that I have performed a pre-participation examination in accordance with
ISSM standards (current edition of Physician and Sports Medicine's Pre-participation Physical Evaluation)
I certify that the above clearance and attached PPE is accurate, complete and compliant to such standards. I
) agree that I have documented and signed any playing restrictions on the High School Athlete.

lthCare Provider's Signature: _____ **Date:**_____

ıted Name:_____ **Title:**_____ **Phone:**_____

ress and/or Physician's Stamp:

Our Lady of Mount Carmel

ATHLETE EMERGENCY CARD

Parents/Guardian: Please take time to FULLY complete this form. It is very important information to have in case of an emergency situation where you cannot be reached. Your child's social security number and insurance information are needed for that purpose only, and will be shared only if absolutely necessary.

Section 1: Contact/Personal Information

Student Name:_____ Sport:_____ SS#:_____

Student Grade:____ Birth Date:____ Guardian's Name:_____

Address:_____

Student Phone: (H)_____ (Cell)_____

Emergency Contact information:

Mother's Name:_____ Phone:_____

Work Phone:_____

Cell Phone:_____

Fathers Name:_____ Phone:_____

Work Phone:_____

Cell Phone:_____

Preference of Physician (and permission to contact if needed):

Name:_____ Phone:_____

Insurance:_____

Policy No:_____ Group:_____ Phone:_____

In case of emergency, contact:_____ Relationship:_____

Phone: (H)_____ (W)_____ (Cell)_____

Section 2: Medical Information

Medical Illnesses:_____

Last Tetanus (Mo/Yr):_____ Allergies:_____

Medications:_____

(Any Medications That May Be Taken During Competition Require A Physician's Note)

Previous Head/Neck/Back Injury:_____

Previous Heat-Related Problems:_____

Previous Significant Injuries:_____

Any Other Important Medical Information:_____

Section 3: Consent for Athletic Conditioning, Training and Health Care Procedures

I hereby give consent for my child to participate in the school's athletic conditioning and training program and to receive any necessary healthcare treatment including first aid, diagnostic procedures, and medical treatment that may be provided by the treating physicians, nurses, athletic trainers, or other healthcare providers employed directly or through a contract the school, or the opposing team's school. The healthcare providers have my permission to release my child's medical information to other healthcare practitioners and school officials. In the event I cannot be reached in an emergency I give permission for my child to be transported to the nearest emergency room based on local EMS protocols to receive necessary treatment.

Permission to Receive and Release Medical Records

I understand that the Our Lady of Mount Carmel athletic trainer, the approved health care provider for OLMC, may request information regarding the athlete's health status from a physicians office, and I hereby give my permission for the receipt and release of this information as it pertains to my child's ability to safely participate in athletics. In addition should treatment be necessary, I give permission for a physician's office to release medical information to allow for the timely treatment of my child by the approved health care provider for OLMC. This request is to facilitate open communication between the athletic trainer and the treating physician in order to optimize patient care. This information cannot and will not be released to other parties without first being approved by the guardian or parent of the athlete. I understand I will be notified of the necessity of obtaining medical records.

Parent/Guardian Signature:_____ Date:_____

Athlete's Signature:_____ Date:_____