

**PRE-PARTICIPATION HISTORY AND PHYSICAL EXAMINATION FOR COUPEVILLE
MIDDLE - HIGH SCHOOL ATHLETES**

Name: _____ Grade: _____ Telephone: _____

Birthdate: _____ Birthplace: _____

Address: _____

Street _____ City _____ State _____ Zip Code _____

Father's Employer: _____ Telephone: _____

Mother's Employer: _____ Telephone: _____

Emergency Contact: _____ Telephone: _____

Preferred Hospital: _____

MEDICAL HISTORY

- | | YES | NO | |
|-----|--------------------------|--------------------------|--|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been "knocked out" or lost consciousness?
Year: _____ |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any "fits" or seizures? Year: _____ |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been hospitalized? Year: _____ |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever required an operation? Year: _____ |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | Have you any organs missing other than tonsils, or appendix?
such as: eye, kidney, testicle, etc: _____ |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | Are you allergic to any medications? _____ |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | Do you take any medication regularly? _____ |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any chronic or recurrent illness? _____ |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have stop while running two laps on a 1/4 mile track? |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | Have any close relative of yours had a heart attack or heart
trouble under age 50? _____ |
| 11. | <input type="checkbox"/> | <input type="checkbox"/> | Do you wear glasses or contact lens? _____ |
| 12. | <input type="checkbox"/> | <input type="checkbox"/> | Do you wear any dental appliances such as a bridge or plate?
_____ |
| 13. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had asthma or breathing difficulty? |
| 14. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had rheumatic fever or a heart murmur? |
| 15. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a dislocated knee, shoulder, hip or other
joint? _____ |

Examiner's Comments to Above:

PARENT PERMISSION: If the parents and/or authorized physician named above cannot be reached at the time of any emergency, and if immediate observation or treatment is urgent in the judgement of the school authorities or the coach, do you authorize and direct the school to send the pupil to the hospital or doctor most easily accessible and for such doctor to render such observation and treatment as is immediately necessary?

YES NO Parent Signature _____ Date _____