BETHEL CHRISTIAN ACADEMY ATHLETICS
PREPARTICIPATION EXAMINATION FORM

Student Athlete's Name: ____ Age: _____ Sex: _____

This is a screening examination for participation in BCA sports. This does not substitute for a comprehensive examination with your child's regular physician where important preventive health information can be covered.

Student-Athlete's Directions: Please review all questions with your parent or legal guardian and answer them to the best of your knowledge.

Parent/Legal Custodian Directions: Please assure that all questions are answered to the best of your knowledge. If you do not understand or are unsure about the answer to a question, please ask your doctor. Not disclosing accurate information may put your child at risk during sports activity.

Physician's Directions: We recommend carefully reviewing these questions and clarifying any "Yes" or Unsure" answers.

Explain "Yes" or "Unsure" answers in the space provided below or on an attached separate sheet if needed.	Yes	No	Unsure
1. Does the student-athlete have any chronic medical illnesses (diabetes, asthma (exercise asthma), kidney problems, etc.)? List:	❑	❑	❑
2. Is the student-athlete presently taking any medications or pills?	❑	❑	❑
3. Does the student-athlete have any allergies (medicine, bees, or other stinging insects, latex)?	❑	❑	❑
4. Does the student-athlete have the sickle cell trait?	❑	❑	❑
5. Has the student-athlete ever had a head injury, been knocked out, or had a concussion?	❑	❑	❑
6. Has the student-athlete ever had a heat injury (heat stroke) or severe muscle cramps with activities?	❑	❑	❑
7. Has the student-athlete ever passed out or nearly passed out DURING exercise, emotion or startle?	❑	❑	❑
8. Has the student-athlete every fainted or passed out AFTER exercise?	❑	❑	❑
9. Has the student-athlete had extreme fatigue (been really tired) with exercise (different from other children)?	❑	❑	❑
10. Has the student-athlete ever had trouble breathing or coughing during or after activities?	❑	❑	❑
11. Has the student-athlete ever been diagnosed with exercise-induced asthma?	❑	❑	❑
12. Has a doctor ever told the student-athlete that they have high blood pressure?	❑	❑	❑
13. Has a doctor ever told the student-athlete that they have a heart infection/murmur?	❑	❑	❑
14. Has the student-athlete ever had discomfort, pain, or pressure in his chest during or after exercise or complained of their heart "racing" or "skipping beats"?	❑	❑	❑
15. Has the student-athlete ever had a seizure or been diagnosed with an unexplained seizure problem?	❑	❑	❑
16. Has the student-athlete ever had a stinger, burner or pinched nerve?	❑	❑	❑
17. Has the student-athlete ever had any problems with their eyes or vision?	❑	❑	❑
18. Does the student-athlete wear glasses, contacts, or protective eye wear?	❑	❑	❑
19. Place a check beside each body part that the student-athlete has ever sprained/strained, dislocated, fractured, broken, had repeated swelling in or had any other type of injury to any bones or joints? ❑ Head ❑ Shoulder ❑ Thigh ❑ Neck ❑ Elbow ❑ Knee ❑ Chest ❑ Hip ❑ Forearm ❑ Shin/calf ❑ Back ❑ Wrist ❑ Ankle ❑ Hand ❑ Foot Other: ___________			
20. Has the student-athlete ever been hospitalized or had surgery?			
21. Has the student-athlete had a medical problem or injury since their last evaluation?			
FAMILY HISTORY			
22. Has any family member had a sudden, unexpected death before age 50?			
23. Has any family member had unexplained heart attacks, fainting or seizures?			
24. Does the athlete have a family member with sickle cell disease?			

Explain "yes" or "unsure" answers here: ____

____

By signing below, I agree that I have reviewed and answered each question above. Every question is answered completely and is correct to the best of my knowledge. Furthermore, as a parent or legal custodian, I give consent for this examination and give permission for my child to participate in BCA sports.

Signature of parent/legal guardian: ______________________________ Date: _________ Phone #: (____)____________

Signature of Athlete: ____ Date: _________

Student-Athlete's Name: ____ **Age:** ____ **Date of Birth:** __________

Height: __________ **Weight:** __________ **BP** ________(____% ile) / ________(____% ile) **Pulse:** __________

Vision: R 20/ ______**L20/**______ **Corrected: Y N** **Pupils** (Circle) **Equal/Unequal R > L R > L**

Physical Examination (Below Must be Completed by Licensed Physician, Nurse Practitioner or Physician Assistant)

			******* *Specific Findings* *******
MARFAN'S SYNDROME STIGMATA	*No*	*Yes*	

Heart:

RHYTHM	*Regular*	*Irregular*	
MURMUR (supine)	*No*	*Yes*	
MURMUR (standing)	*No*	*Yes*	

	Normal	*Abnormal*	******* *Specific Findings* *******
LUNGS			
SKIN			
NECK/BACK			
SHOULDERS			
ELBOWS			
HANDS/WRISTS			
KNEES			
ANKLE/FOOT			
OTHER			

Optional Examination Elements - Should be done if history indicates

HEENT			
ABDOMINAL			
FEMORAL PULSES			
GENITALIA/HERNIA (MALES)			

Clearance:

A. Cleared

B. Cleared after completing evaluation/rehabilitation for: ____

C. Not cleared

Due to: ____

Additional Recommendation/Rehab Instructions: ____

____

____

Name of Physician/Extender: _______________________________________ (Please print)

Signature of Physician/Extender: ____________________________________ MD DO PA NP (Please circle)

Date of Examination: __________________

Address: ___________________________________ Phone: (_____)______________

____