IHSA IESA Pre-participation Examination

To be completed by athlete or parent prior to examination.

Name_____ Sport/Position_____
Last First Middle

Social Security Number_____ School Year_____

Address_____

City/State_____ Phone No._____

Birthdate_____ Age_____ Class_____ Student ID No._____

Parent's Name_____

Address_____

Phone No._____

Person to contact in case of emergency_____

Phone No._____

Family Doctor_____ City/State_____

Phone No._____

Past Medical History

		Yes	No	If yes, please explain (what, where, when)
1.	Presently taking medication (including birth control pills)?			
2.	Have you been diagnosed with asthma?			
3.	Have you been prescribed by a physician to use any asthma medication?			
4.	Do you have a current consent form to self-administer the asthma medication on file with your school?			
5.	Allergic to medicine, foods, bee stings?			
6.	Wears any appliances – glasses, contact lenses?			
7.	History of braces, chipped teeth, bridges?			
8.	Has ongoing medical problem?			
9.	Had serious or significant illness in past?			
10.	Any past surgical operations, accidents, non-sports or related injuries?			
11.	Any past injuries directly related to sports?			
12.	Any hospitalization not explained above?			
13.	Any known deformities (such as curvature of back, heart problems, one kidney, blindness in one eye, one testicle, etc.)?			
14.	Any serious family illness (such as diabetes, bleeding disorders, etc.)?			
15.	Family history of cancer?			
16.	Heart			
	Have you ever passed out during or after exercise?			
	Have you ever had chest pain during or after exercise?			
	Do you get tired more quickly than your friends do during exercise?			
	Have you ever had racing of your heart or skipped heartbeats?			
	Have you had high blood pressure or high cholesterol?			
	Have you ever been told you have a heart murmur?			
	Has any family member or relative died of heart problems or of sudden death before age 50?			
	Have you had a severe viral infection (for example myocarditis or mononucleosis) within the last month?			
	Has a physician ever denied or restricted your participation in sports for any heart problems?			
	Has anyone in your family had a heart attack before the age of 50?			
17.	Head and Nerve			
	Have you ever had a head injury or concussion?			
	Have you ever been knocked out, become unconscious, or lost your memory?			
	Have you ever had a seizure?			
	Do you have frequent or severe headaches?			
	Have you ever had numbness or tingling in your arms, hands, legs or feet?			
	Have you ever had a stinger, burner, or pinched nerve?			
18.	Last tetanus shot?	Date		
19.	Last eye exam?	Date		
20.	Last Menstrual period (if women)	Date		

Personal Habits

		Yes	No
1.	Smoking/smokeless tobacco		
2.	Alcohol/non-medical drugs: marijuana, cocaine, etc.		
3.	Steroids		
4.	Easting Disorders – weight loss or gain?		

Review of systems (Please check if you have any problems with any of the following areas of your body)

_____	Skin	_____	Lungs	_____	Shoulders, Arms, Hands
_____	Head	_____	Heart	_____	Hips, Legs, Feet
_____	Eyes	_____	Abdomen	_____	Muscle–Strength, Feeling
_____	Nose	_____	Back	_____	Mental, Emotional
_____	Mouth/Throat	_____	Urination, Bowel Control	_____	Fatigue
_____	Nutrition, Weight Control	_____	Genital (including menstrual for women)	_____	Other: What?
_____	Neck	_____			

I certify that the above information is correct to the best of my knowledge.

Student Signature_____

Parent/Guardian Signature_____

Both Student and Parent/Guardian Signatures Are Mandatory