

# APPENDIX B

This is a "sample" form and should be reviewed and edited as necessary by a licensed physician to better suit your own particular situation and locale. Such a form serves to verify the medical history and readiness level of the perspective cheer participant. It should be signed and dated by the athlete, his/her parent and/or legal guardian as well as his/her physician where noted and kept on permanent file for ready reference.

SAMPLE

## PRE-PARTICIPATION EXAMINATION

### PART I - MEDICAL HISTORY

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_  
Parent/Guardian Name \_\_\_\_\_ Emergency Telephone \_\_\_\_\_  
School/Gymnastics Club/Organization \_\_\_\_\_ Coach's Name \_\_\_\_\_  
Doctor's Name \_\_\_\_\_ Doctor's Telephone \_\_\_\_\_

#### **MEDICAL HISTORY**

Directions: Check the box for yes or no. Some "yes" answers require explanations; please provide them where appropriate.

#### **IMMUNIZATIONS**

	<b>Yes</b>	<b>No</b>
Poliomyelitis .....	<input type="checkbox"/>	<input type="checkbox"/>
Measles .....	<input type="checkbox"/>	<input type="checkbox"/>
Tetanus—Date of last booster: _____ .....	<input type="checkbox"/>	<input type="checkbox"/>

#### **GENERAL**

Are you currently taking any medications? .....

If so, list them here: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any allergies to foods, drugs, bees or other stinging insects? .....

If so, list them here: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had any illnesses in the last two years? .....

If so, list them here: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever been hospitalized? .....

If so, list the dates and operations: Date: \_\_\_\_\_ Reason: \_\_\_\_\_

Date: \_\_\_\_\_ Reason: \_\_\_\_\_

Date: \_\_\_\_\_ Reason: \_\_\_\_\_

	<b>Yes</b>	<b>No</b>
Have you ever had any surgery? .....	<input type="checkbox"/>	<input type="checkbox"/>
If so, list the dates and operations: Date: _____ Reason: _____		
Date: _____ Reason: _____		
Date: _____ Reason: _____		
Have you ever had infectious mononucleosis? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had hay fever? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any problems with heat (cramps, stroke, exhaustion, etc.)? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have frequent nausea and/or vomiting? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have hemophilia or a bleeding disorder? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have diabetes? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you tire more quickly than your friends during exercise? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have anemia? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have thyroid disease? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have arthritis? .....	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone in your family died suddenly before age 40? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been advised by a medical doctor not to participate in any athletic activity? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any missing body parts (eye, kidney, etc.)? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you use any special pads, braces, or guards? .....	<input type="checkbox"/>	<input type="checkbox"/>

## **DENTAL**

Do you wear or have a <u>dental bridge/crown/plate/retainer/braces</u> ? (Circle the appropriate response(s)) .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have bleeding gums? .....	<input type="checkbox"/>	<input type="checkbox"/>

## **EYES**

Do you have poor vision in either eye? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear <u>glasses</u> or <u>contact lenses</u> ? (Circle the appropriate response(s)) .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear protective eye wear? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have blurred vision? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have double vision? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any eye injuries? .....	<input type="checkbox"/>	<input type="checkbox"/>

## **EAR, NOSE, AND THROAT**

Do you have frequent nosebleeds? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have frequent sore throats? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have frequent ear infections? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you noticed decreased hearing in either ear? .....	<input type="checkbox"/>	<input type="checkbox"/>

## **CARDIOVASCULAR**

Have you ever been told that you have a heart murmur? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have high blood pressure? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you ever get any chest pain? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you ever get palpitations (extra-strong or skipped beats, or racing of your heart)? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had phlebitis? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a family history of heart attacks before the age of 50? .....	<input type="checkbox"/>	<input type="checkbox"/>

## CHEST/PULMONARY

	Yes	No
Do you frequently have a productive cough? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever coughed up blood? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had pneumonia? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had tuberculosis? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have asthma, or do you ever wheeze? .....	<input type="checkbox"/>	<input type="checkbox"/>
Are you frequently short of breath? .....	<input type="checkbox"/>	<input type="checkbox"/>

## ABDOMINAL

Do you ever get indigestion/heartburn? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have frequent abdominal pain? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have, or have you ever had, an ulcer? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had hepatitis? .....	<input type="checkbox"/>	<input type="checkbox"/>
Are you frequently constipated? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have diarrhea often? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you ever have blood in your stools (bowel movements) or black, tarry stools? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a hernia? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have pain or burning with urination? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you ever have blood in your urine? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you ever have dark-colored urine? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have to urinate very frequently? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a kidney stone? .....	<input type="checkbox"/>	<input type="checkbox"/>

## GYNECOLOGIC (Females only)

Have you started monthly menstrual periods? .....	<input type="checkbox"/>	<input type="checkbox"/>
When was your first menstrual period? _____		
When was your last menstrual period? _____		
When was the longest time between periods last year? _____		
Are your periods regular? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have heavy bleeding with your periods? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you take birth control pills? .....	<input type="checkbox"/>	<input type="checkbox"/>

## NEUROLOGIC

Do you have occasional dizziness? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you ever faint or pass out? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you get frequent and severe headaches? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a head injury, concussion, or loss of consciousness? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a neck injury? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a stinger, burner, or pinched nerve? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had episodes of numbness or weakness in your arms and/or legs? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had seizures or epilepsy? If yes, give date of most recent seizure: _____ .....	<input type="checkbox"/>	<input type="checkbox"/>

**SKIN**

**Yes**      **No**

- Are you prone to skin infections? .....
- Do you have acne? .....
- Do you get frequent rashes? .....

**ORTHOPEDIC**

- Have you ever had any fractures, broken bones, or dislocations? .....
- If so, list them here:  Neck       Shoulder       Arm       Elbow       Forearm  
 Wrist       Hand       Spine/Back       Pelvis       Hip  
 Thigh       Knee       Leg       Ankle       Foot
- Do you have chronic pain in any of the following regions? .....
- If so, list them here:  Neck       Shoulder       Arm       Elbow       Forearm  
 Wrist       Hand       Spine/Back       Pelvis       Hip  
 Thigh       Knee       Leg       Ankle       Foot
- Do you have scoliosis? .....
- Do you have spondylolysis (stress fracture of the low back) or spondylolisthesis? .....
- Have you had occasional hamstring muscle strains/pulls? .....
- Has anyone ever told you that you have Osgood-Schlatter’s disease? .....
- Have you ever had a cartilage tear in the knee? .....
- Have you ever had a ligament sprain/injury in the knee? .....
- Have you ever had shin splints or a stress fracture in your leg? .....
- Have you had achilles tendinitis? .....
- Do you get frequent ankle sprains? .....
- Do your ankles hurt when you land short? .....

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

Signature of athlete \_\_\_\_\_ Date \_\_\_\_\_

Signature of parent or guardian \_\_\_\_\_ Date \_\_\_\_\_

**PART II - EMERGENCY MEDICAL TREATMENT STATEMENT**

I, the parent and/or legal guardian of \_\_\_\_\_, give permission for emergency medical treatment of my child if I cannot first be contacted.

Signature of parent or guardian \_\_\_\_\_ Date \_\_\_\_\_

Telephone: (home) \_\_\_\_\_ (cell) \_\_\_\_\_

(work) \_\_\_\_\_ Emergency Contact \_\_\_\_\_

EMERGENCY \_\_\_\_\_ Relationship to Child \_\_\_\_\_

Telephone \_\_\_\_\_

## **PART III - PHYSICAL EXAMINATION**

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ BP: \_\_\_\_\_ / \_\_\_\_\_ PULSE: \_\_\_\_\_

VISION: R-20/ \_\_\_\_\_ L-20/ \_\_\_\_\_ CORRECTED Y / N PUPILS: \_\_\_\_\_

	<b>NORMAL</b>	<b>ABNORMAL</b>	<b>PHYSICIAN'S INITIALS</b>
EAR	_____	_____	_____
NOSE	_____	_____	_____
THROAT	_____	_____	_____
DENTAL	_____	_____	_____
CARDIAC	_____	_____	_____
PERIPHERAL PULSES	_____	_____	_____
CHEST	_____	_____	_____
ABDOMEN	_____	_____	_____
GENITALIA	_____	_____	_____
SKIN	_____	_____	_____
NEUROLOGIC	_____	_____	_____
MUSCULOSKELETAL	_____	_____	_____
Neck	_____	_____	_____
Back	_____	_____	_____
Shoulder	_____	_____	_____
Elbow	_____	_____	_____
Wrist	_____	_____	_____
Hand	_____	_____	_____
Pelvis/Hip	_____	_____	_____
Knee	_____	_____	_____
Leg	_____	_____	_____
Ankle	_____	_____	_____
Foot	_____	_____	_____

**PART IV - LABORATORY TESTS**

CBC: \_\_\_\_\_

URINALYSIS: \_\_\_\_\_

OTHER: \_\_\_\_\_

\_\_\_\_\_

**PART V - CLEARANCE**

FINAL DISPOSITION:

- Full participation
- Limited participation with following restrictions: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- No participation until further evaluation and/or rehabilitation:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- No participation due to: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

RECOMMENDATIONS:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Date: \_\_\_\_\_