

School Attending: _____
 Desired Sport: _____
 Desired Level: Modified Freshman JV Varsity

Rochester City School District
 Interscholastic Athletics
 Pre-Participation Form



Student Name: _____	Gender: M F	Birthdate: _____	Age: _____
Name of Parent/Guardian: _____	Phone Number: _____ Home Work Cell		
Name of Emergency Contact: _____	Phone Number: _____ Home Work Cell		
Address & Zip: _____	Grade: _____	Date Entered Grade 9: _____	

Completed by Parent/Guardian: Answer the questions below completely and correctly, to the best of your knowledge.

- | | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Has a doctor ever denied or restricted your participation in sports for any reason? | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have any ongoing medical concerns? If yes, please identify: <input type="checkbox"/> asthma <input type="checkbox"/> diabetes <input type="checkbox"/> life-threatening allergies
<input type="checkbox"/> other: _____ | <input type="checkbox"/> | <input type="checkbox"/> | 14. Have you ever had any broken or fractured bones or dislocated joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever spent the night in the hospital? | <input type="checkbox"/> | <input type="checkbox"/> | 15. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | 16. Have you ever had a stress fracture? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever passed out or nearly passed out during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 17. Do you regularly use a brace, orthotics, or other assistive device? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 18. Do you have a bone, muscle, or joint that currently bothers you? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Does your heart ever race or skip beats (irregular beats) during exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 19. Do you cough, wheeze, or have difficulty breathing during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Has a doctor ever told you that you have any heart problems? If yes, please identify: <input type="checkbox"/> high blood pressure <input type="checkbox"/> high cholesterol <input type="checkbox"/> a heart murmur <input type="checkbox"/> a heart infection
<input type="checkbox"/> Kawasaki disease <input type="checkbox"/> other: _____ | <input type="checkbox"/> | <input type="checkbox"/> | 20. Have you ever used an inhaler or taken asthma medication? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Has a doctor ever ordered a test for your heart (i.e. ECG/EKG, echocardiogram)? | <input type="checkbox"/> | <input type="checkbox"/> | 21. Were you born without or are you missing a kidney, an eye, a testicle, your spleen, or any other organ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you get unbearably lightheaded or short of breath during exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 22. Have you had infectious mononucleosis (mono) within the last month? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 40? | <input type="checkbox"/> | <input type="checkbox"/> | 23. Do you currently have any rashes, sores, or other skin problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Does anyone in your family have any heart problems? | <input type="checkbox"/> | <input type="checkbox"/> | 24. Have you ever had a MRSA skin infection? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 25. Have you ever had a head injury or concussion? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 26. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 27. Do you have a history of seizure disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 28. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 29. Have you ever become ill after while exercising in the heat? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 30. Do you get frequent muscle cramps when exercising? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 31. Do you sickle cell disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 32. Have you had any problems with your vision or hearing? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 33. Are you currently taking any medication? | <input type="checkbox"/> | <input type="checkbox"/> |

This certifies that, with the following requirements, the above student is qualified to participate in interscholastic athletics.

Completed by School Nurse:

Requirements:

- glasses, contact lenses, or protective eyewear
 asthma inhaler diabetic supplies epi-pen
 other medical requirements: _____

 current prescriptions & OTC medications: _____

Nurse Signature:		Date:	
Athletic Director Signature:		Date:	

Name of Physician: _____

Name of Health Center: _____

Date of Last Physical: _____

Females Only:

Have you ever had a menstrual period? Yes No

If yes, at what age did you begin menstruating? _____

Explain "Yes" answers below:

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct, and therefore, I
 _____, **have no reason to disallow** _____ **from participation in interscholastic athletics.**
(name of parent/guardian) (name of student)

Student Signature: _____ **Parent/Guardian Signature:** _____ **Date:** _____