Young Women's College Prep - Athletics Pre-Participation Form

Student Name:	DOB
School Name:	Age
Grade (circle): 7 8 9 10 11 12	Limitations (cirlce) : NO YES
Sport:	Date of last Health Exam:
Sport Level (circle): Modified Fresh JV Varsity	

MUST be completed and signedby Parent/Guardian - Give details to any YES answers on the last page.

DOES OR HAS YOUR CHILD

GENERAL HEALTH	NO	YES
Ever been restricted by a health care provider from sports participation for any reason?	☐	☐
Ever had surgery?	☐	☐
Ever spent the night in a hospital?	☐	☐
Been diagnosed with mononucleosis within the last month?	☐	☐
Have only one functioning kidney?	☐	☐
Have a bleeding disorder?	☐	☐
Have any problems with hearing or have congenital deafness?	☐	☐
Have any problems with vision or only have vision in one eye?	☐	☐
Have an ongoing medical condition?	☐	☐

If yes, check all that apply:

☐ Asthma ☐ Diabetes
☐ Seizures ☐ Sickle cell trait or disease
☐ Other:

Have Allergies?	☐	☐

If yes, circle all that apply

Food Insect Bite Latex Medicine
Pollen Other:

Ever had anaphylaxis?	☐	☐
Carry an epinephrine auto-injector?	☐	☐

BRAIN/HEAD INJURY HISTORY	NO	YES
Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told they had a concussion?	☐	☐
Receive treatment for a seizure disorder or epilepsy?	☐	☐
Ever had headaches with exercise?	☐	☐
Ever had migraines?	☐	☐

DOES OR HAS YOUR CHILD

BREATHING	NO	YES
Ever complained of getting extremely tired or short of breath during exercise?	☐	☐
Use or carry an inhaler or nebulizer?	☐	☐
Wheeze or cough frequently during or after exercise?	☐	☐
Ever been told by a health care provider they have asthma or exercise-induced asthma?	☐	☐
DEVICES / ACCOMMODATIONS	**NO**	**YES**
Use a brace, orthotic, or another device?	☐	☐
Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)?	☐	☐
Wear protective eyewear, such as goggles or a face shield?	☐	☐
Wear a hearing aid or cochlear implant?	☐	☐

Let the coach/school nurse know of any device used.
Not required for contact lenses or eyeglasses.

DIGESTIVE (GI) HEALTH	NO	YES
Have stomach or other GI problems?	☐	☐
Ever had an eating disorder?	☐	☐
Have a special diet or need to avoid certain foods?	☐	☐
Are there any concerns about your child's weight?	☐	☐
INJURY HISTORY	**NO**	**YES**
Ever been unable to move their arms or legs or had tingling, numbness, or weakness after being hit or falling?	☐	☐
Ever had an injury, pain, or swelling of a joint that caused them to miss practice or a game?	☐	☐
Have a bone, muscle, or joint that bothers them?	☐	☐
Have joints that become painful, swollen, warm, or red with use?	☐	☐
Ever been diagnosed with a stress fracture?	☐	☐

Student Name:	DOB

Does or Has Your Child

Heart Health	No	Yes
Ever complained of:		
Ever had a heart test? (EKG, Stress Test, Echo)	☐	☐
Lightheadedness, dizziness during/after exercise?	☐	☐
Chest Pain, tightness/pressure during/after exercise?	☐	☐
Flutter in chest, skipped breath, racing heart?	☐	☐
Have an ongoing medical condition?	☐	☐

If yes, check all that apply:

- ☐ Chest Tightness/Pain
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ New Fast/Slow HR
- ☐ Has Implanted Cardiac Defibrillator (ICD)
- ☐ Has a Pacemaker
- ☐ Heart Infection
- ☐ Heart Murmur
- ☐ Low Blood Pressure
- ☐ Kawasaki Disease
- ☐ Other:

Does or Has Your Child

	No	Yes
Have Regular periods?	☐	☐
Have any rashes, pressure sores, or other skin problems?	☐	☐
Ever had herpes or a MERSA skin Infection?	☐	☐
COVID-19 Info	**No**	**Yes**
Has your child ever tested positive for covid?	☐	☐
If **NO, STOP.** Go to Family Heart Health History. If **YES,** answer questions below:		
Date of positive COVID test:		
Was your child symptomatic?	☐	☐
Did your child see a health care provider for their COVID-19 symptoms?	☐	☐
Was your child hospitalized for COVID?	☐	☐
Was your child diagnosed with Multisystem Inflammatory Syndrome (MISC)?	☐	☐

Family Heart History

A relative has/had any of the following (Check All that Apply):

- ☐ Enlarged Heart/ Hypertrophic Cardiomyopathy/ Dilated Cardiomyopathy
- ☐ Arrhythmogenic Right Ventricular Cardiomyopathy?
- ☐ Heart rhythm problems, long or short QT interval?
- ☐ Pacemaker or implanted cardiac defibrillator (ICD)?
- ☐ Brugada Syndrome?
- ☐ Catecholaminergic Ventricular Tachycardia?
- ☐ Marfan Syndrome (aortic rupture)?
- ☐ Heart attack at age 50 or younger?

A Family History of (Check All that Apply):

- ☐ Known heart abnormalities or sudden death before age 50?
- ☐ Structural heart abnormality, repaired or unrepaired?
- ☐ Unexplained fainting, seizures, drowning, near drowning, or car accident before age 50?

Please explain any Yes Answers here:

Parent/Guardian Signature: Date: