

(The parent or guardian should fill out this form with assistance from the student-athlete)

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

Name: \_\_\_\_\_  
 Home Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 Age: \_\_\_\_\_  
 Gender: \_\_\_\_\_  
 Grade: \_\_\_\_\_  
 School: \_\_\_\_\_  
 Sport(s): \_\_\_\_\_  
 Personal Physician: \_\_\_\_\_  
 Hospital Preference: \_\_\_\_\_

In case of emergency contact:  
 Name: \_\_\_\_\_  
 Relationship: \_\_\_\_\_  
 Phone (Home): \_\_\_\_\_  
 Phone (Work): \_\_\_\_\_  
 Phone (Cell): \_\_\_\_\_  
 -----  
 Name: \_\_\_\_\_  
 Relationship: \_\_\_\_\_  
 Phone (Home): \_\_\_\_\_  
 Phone (Work): \_\_\_\_\_  
 Phone (Cell): \_\_\_\_\_

Explain "Yes" answers on the following page.  
 Circle questions you don't know the answers to.

	Y	N
1) Has a doctor ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
2) Do you have an ongoing medical conditional (like diabetes or asthma)?	<input type="checkbox"/>	<input type="checkbox"/>
3) Are you currently taking any prescription or nonprescription (over-the-counter) medicines or supplements? (Please specify): _____	<input type="checkbox"/>	<input type="checkbox"/>
4) Do you have allergies to medicines, pollens, foods or stringing insects? (Please specify): _____	<input type="checkbox"/>	<input type="checkbox"/>
5) Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
6) Has a doctor ever told you that you have (check all that apply):	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> A Heart Murmur <input type="checkbox"/> High Cholesterol <input type="checkbox"/> A Heart Infection		
7) Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>
8) Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
9) Have you ever had an injury (sprain, muscle/ligament tear, tendinitis, etc.) that caused you to miss a practice or game? (If yes, check affected area in the box below in question 11)	<input type="checkbox"/>	<input type="checkbox"/>
10) Have you had any broken/fractured bones or dislocated joints? (If yes, check affected area in the box below in question 11):	<input type="checkbox"/>	<input type="checkbox"/>
11) Have you had a bone/joint injury that required X-rays, MRI, CT, surgery, injections, rehabilitation physical therapy, a brace, a cast or crutches? (If yes, check affected area in the box below):	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Shoulder <input type="checkbox"/> Upper Arm <input type="checkbox"/> Elbow <input type="checkbox"/> Forearm		
<input type="checkbox"/> Hand/Fingers <input type="checkbox"/> Chest <input type="checkbox"/> Upper Back <input type="checkbox"/> Lower Back <input type="checkbox"/> Hip <input type="checkbox"/> Thigh		
<input type="checkbox"/> Knee <input type="checkbox"/> Calf/Shin <input type="checkbox"/> Ankle <input type="checkbox"/> Foot/Toes		

	<b>Y</b>	<b>N</b>
12) Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>
13) Have you ever been told that you have, or have you had an X-ray for atlantoaxial (neck) instability?	<input type="checkbox"/>	<input type="checkbox"/>
14) Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>
15) Has a doctor told you that you have asthma or allergies?	<input type="checkbox"/>	<input type="checkbox"/>
16) Do you cough, wheeze or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
17) Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>
18) Have you ever used an inhaler or taken asthma medication?	<input type="checkbox"/>	<input type="checkbox"/>
19) Were you born without, are you missing, or do you have a non-functioning kidney, eye, testicle or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
20) Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
21) Do you have any rashes, pressure sores or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
22) Have you had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
23) Have you ever had an injury to your face, head, skull or brain (including a concussion, confusion, memory loss or headache from a hit to your head, having your "bell rung" or getting "dinged")?	<input type="checkbox"/>	<input type="checkbox"/>
24) Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
25) Have you ever had numbness, tingling or weakness in your arms or legs after being hit, falling, stingers or burners?	<input type="checkbox"/>	<input type="checkbox"/>
26) While exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>
27) Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
28) Have you ever been tested for sickle cell trait?	<input type="checkbox"/>	<input type="checkbox"/>
29) Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
30) Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
31) Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
32) Are you happy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>
33) Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
34) Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>
35) Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>
36) Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>

**Females Only**

**Explain "Yes" Answers Here**

	<b>Y</b>	<b>N</b>
37) Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
38) How old were you when you had your first menstrual period?	_____	
39) How many periods have you had in the last year?	_____	

The physician should fill out this form with assistance from the parent or guardian.)

Student Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Patient History Questions: Please Tell Me About Your Child...**

	<b>Y</b>	<b>N</b>
1) Has your child fainted or passed out DURING or AFTER exercise, emotion or startle?	<input type="checkbox"/>	<input type="checkbox"/>
2) Has your child ever had extreme shortness of breath during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
3) Has your child had extreme fatigue associated with exercise (different from other children)?	<input type="checkbox"/>	<input type="checkbox"/>
4) Has your child ever had discomfort, pain or pressure in his/her chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
5) Has a doctor ever ordered a test for your child's heart?	<input type="checkbox"/>	<input type="checkbox"/>
6) Has your child ever been diagnosed with an unexplained seizure disorder?	<input type="checkbox"/>	<input type="checkbox"/>
7) Has your child ever been diagnosed with exercise-induced asthma not well controlled with medication?	<input type="checkbox"/>	<input type="checkbox"/>

**Explain "Yes" Answers Here**

**COVID-19...**

	<b>Y</b>	<b>N</b>
1) Has your child been diagnosed with COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
1a) If yes, is your child still having symptoms from their COVID-19 infection?	<input type="checkbox"/>	<input type="checkbox"/>
2) Was your child hospitalized as a result for complications of COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
3) Has your child been diagnosed with Multi-Inflammatory Syndrome in Children (MIS-C)?	<input type="checkbox"/>	<input type="checkbox"/>
4) Did your child have any special tests ordered for their heart or lungs or were referred to a heart specialist (cardiologist) to be cleared to return to sports?	<input type="checkbox"/>	<input type="checkbox"/>
5) Has your child returned back to full participation in sports?	<input type="checkbox"/>	<input type="checkbox"/>
6) Has your child had direct or known exposure to someone diagnosed with COVID-19 in the past 3 months?	<input type="checkbox"/>	<input type="checkbox"/>
6a) Was your child tested for COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
7) Did your child receive the COVID-19 vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
7a) What was the manufacturer of the vaccine? _____		
7b) Date of vaccination(s) _____		

**Explain "Yes" Answers Here**

**Patient Health Questionnaire Version 4 (PHQ-4)**

Over the last two weeks, how often have you been bothered by any of the following problems? (circle responses)

	<b>Not At All</b>	<b>Several Days</b>	<b>Over Half The Days</b>	<b>Nearly Every Day</b>
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

*(A sum of ≥ 3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)*

If you score a sum of 3 or greater on either questions 1 and 2, or 3 and 4, you may have anxiety or depression that is affecting you more than normal. In this case, it is recommended that you talk to a trusted health care provider such as your primary care physician, your athletic trainer at school, or a counselor at school. If there is not someone you feel comfortable talking to or you are interested in learning more to help yourself or a friend, please use the resources provided below.

For more information regarding student-athlete mental health:  
[Quiet Suffering - A Resource for Student-Athlete Mental Health](https://spark.adobe.com/page/lltwyoLpTAp0V/)  
[spark.adobe.com/page/lltwyoLpTAp0V/](https://spark.adobe.com/page/lltwyoLpTAp0V/)

Teen Lifeline Call and Text Crisis Line  
(602) 248-8336 (TEEN)

Outside Maricopa county call: 1-800-248-8336 (TEEN)

Hours are: Call 24/7/365 | Text weekdays 12-9 p.m. & weekends 3-9 p.m. | Peer counseling 3-9 p.m. daily

Crisis text line: Text HOME to 741741 to connect with a crisis counselor

National Suicide Prevention Lifeline  
1-800-273-8255 or [suicidepreventionlifeline.org](https://suicidepreventionlifeline.org)

The Trevor Lifeline  
866-488-7386 (for gender diverse youth)

**Family History Questions: Please Tell Me About Any Of The Following In Your Family...**

		<b>Y</b>	<b>N</b>			<b>Y</b>	<b>N</b>
1)	Are there any family members who had sudden/unexpected/unexplained death before age 50? (including SIDS, car accidents, drowning or near drowning)	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
2)	Are there any family members who died suddenly of "heart problems" before age 50?	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
3)	Are there any family members who have unexplained fainting or seizures?	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
4)	Are there any relatives with certain conditions, such as:						
		<b>Y</b>	<b>N</b>			<b>Y</b>	<b>N</b>
	Enlarged Heart	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
	Hypertrophic Cardiomyopathy (HCM)	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
	Dilated Cardiomyopathy (DCM)	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
	Heart Rhythm Problems	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
	Long QT Syndrome (LQTS)	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
	Short QT Syndrome	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
	Brugada Syndrome	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
	Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT)	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
	Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC)	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
	Marfan Syndrome (Aortic Rupture)	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
	Heart Attack, Age 50 or Younger	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
	Pacemaker or Implanted Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
	Deaf at Birth	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>

**Explain "Yes" Answers Here**

**I hereby state that, to the best of my knowledge, my answers to all of the above questions are complete and correct. Furthermore, I acknowledge and understand that my eligibility may be revoked if I have not given truthful and accurate information in response to the above questions.**

\_\_\_\_\_  
Signature of Student-Athlete                      Signature of Parent/Guardian                      Date

\_\_\_\_\_  
Signature of MD/DO/ND/NMD/NP/PA-C/CCSP                      Date