



## Pre-participation Evaluation for Competitive Athletics

*Please read these instructions before filling out the Mount Holyoke Pre-participation Evaluation for  
Competitive Athletics Form.*

If you are planning to participate or feel there is the possibility that you will participate in **varsity or club sports**, complete and sign the front of this form. Your health care provider must complete and sign the second side and clearly indicate a clearance or recommendations regarding your participation. The physical exam must have been done no earlier than **March 2009** for fall entrants and **August 2009** for spring entrants and must include an exam for competitive sports. Students who do not submit all required health forms to Health Services prior to practice dates will not be allowed to participate in team practice. All students are encouraged to fill out this form.

**DUE DATE: JULY 1, 2009**



# Preparticipation Evaluation for Competitive Athletics

NAME \_\_\_\_\_ LAST \_\_\_\_\_ FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

**STUDENT: Answer Yes or No. Explain "Yes" answers below. Circle questions you don't know the answers to.**

- |  |            |          |           |           |           |              |              |       |            |            |     |       |      |           |       |           |   |
|--|------------|----------|-----------|-----------|-----------|--------------|--------------|-------|------------|------------|-----|-------|------|-----------|-------|-----------|---|
| <p>1. Have you ever passed out or nearly passed out DURING exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Have you ever passed out or nearly passed out AFTER exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Have you ever had discomfort, pain, or pressure in your chest during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Does your heart race or skip beats during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Has a doctor ever told you that you have (check all that apply):</p> <p><input type="checkbox"/> High blood pressure    <input type="checkbox"/> A heart murmur<br/><input type="checkbox"/> High cholesterol        <input type="checkbox"/> A heart infection</p> <p>6. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)* <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Has anyone in your family died for no apparent reason? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below.* <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Have you had any broken or fractured bones or dislocated joints? If yes, circle below.* <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below.*</p> <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"><tr><td>Head</td><td>Neck</td><td>Shoulder</td><td>Upper arm</td><td>Elbow</td><td>Forearm</td><td>Hand/fingers</td><td>Chest</td></tr><tr><td>Upper back</td><td>Lower back</td><td>Hip</td><td>Thigh</td><td>Knee</td><td>Calf/shin</td><td>Ankle</td><td>Foot/toes</td></tr></table> <p>11. Have you ever had a stress fracture?* <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?* <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Do you regularly use a brace or assistive device? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | Head       | Neck     | Shoulder  | Upper arm | Elbow     | Forearm      | Hand/fingers | Chest | Upper back | Lower back | Hip | Thigh | Knee | Calf/shin | Ankle | Foot/toes | <p>14. Has a doctor ever told you that you have asthma or allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>15. Do you cough, wheeze, or have difficulty breathing during or after exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>16. Have you ever used an inhaler or taken asthma medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>17. Were you born without or are you missing a kidney, an eye, or any other organ? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>18. Have you had infectious mononucleosis (mono) within the last month? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>19. Do you have any rashes, pressure sores, or other skin problems? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>20. Have you ever had a head injury or concussion? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>21. Have you been hit in the head and been confused or lost your memory? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>22. Have you ever had a seizure? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>23. Do you have headaches with exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>24. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>25. Have you ever been unable to move your arms or legs after being hit or falling? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>26. When exercising in the heat, do you have severe muscle cramps or become ill? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>27. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>28. Have you had any problems with your eyes or vision? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>29. Do you wear glasses or contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>30. Do you wear protective eyewear, such as goggles or a face shield? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>31. Are you happy with your weight? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>32. Are you trying to gain or lose weight? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>33. Has anyone recommended you change your weight or eating habits? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>34. Do you limit or carefully control what you eat? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>35. Do you have any concerns that you would like to discuss with a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
| Head   | Neck       | Shoulder | Upper arm | Elbow     | Forearm   | Hand/fingers | Chest        |       |            |            |     |       |      |           |       |           |   |
| Upper back   | Lower back | Hip      | Thigh     | Knee      | Calf/shin | Ankle        | Foot/toes    |       |            |            |     |       |      |           |       |           |   |

**Explain "Yes" answers here (include dates).** \_\_\_\_\_

\*Explain if this is a current concern. \_\_\_\_\_

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

**SIGNATURE OF ATHLETE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**DUE DATE: JULY 1, 2009**

## Pre-participation Evaluation for Competitive Athletics

NAME \_\_\_\_\_  
LAST FIRST MIDDLE DATE OF BIRTH

**EXAMINER: Please complete the following:**

**FOLLOW-UP QUESTIONS**

**Yes No**

- 1. Do you feel stressed out or under a lot of pressure?
- 2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?
- 3. Do you feel safe?
- 4. Have you ever tried cigarette smoking, even one or two puffs? Do you currently smoke?
- 5. During the past 30 days, have you had at least one drink of alcohol?  
Number of drinks this past week \_\_\_\_\_
- 6. Have you ever used drugs (marijuana, cocaine, heroin, LSD, amphetamines, etc.)?  
Last use \_\_\_\_\_
- 7. Have you ever taken any over-the-counter medications to help you gain or lose weight or improve your performance?
- 8. Have you ever been treated for ADD or ADHD. If yes, list current medication and dosage.

**On this date I have reviewed the medical and preparticipation history and examined this student.**

**On this basis, the student is:**

**CLEARED**

**NOT CLEARED**

- No restrictions
- The following restrictions (explained below)
- Deferred
- Not fit (give reason below)

**EXPLANATIONS:**

HEALTH CARE PROVIDER SIGNATURE REQUIRED

EXAMINER'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_