

River City Rowing Club Junior Crew

HISTORY

Preparticipation Physical Form 2006-2007

Date of Exam _____

Name _____ Age _____ Date of Birth _____

Grade _____ Sport Rowing

Address _____ Phone _____

Personal Physician _____

In case of emergency, contact: Name _____ Relationship _____

Phone (H) _____ (W) _____ (C) _____

Explain "Yes" answers below:

Circle questions you don't know the answer to.

	Yes	No		Yes	No
1. Have you had a medical illness or injury since your last checkup or sports physical?	_____	_____	9. - Do you cough, wheeze, or have trouble breathing during or after activity?	_____	_____
2. - Have you ever been hospitalized overnight?	_____	_____	- Do you have asthma?	_____	_____
- Have you ever had surgery?	_____	_____	- Do you have seasonal allergies that require medical treatment?	_____	_____
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?	_____	_____	10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	_____	_____
4. - Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	_____	_____	11. - Have you had any problems with your eyes or vision?	_____	_____
- Have you ever had a rash or hives develop during or after exercise?	_____	_____	- Do you wear glasses, contacts, or protective eyewear?	_____	_____
5. - Have you ever passed out during or after exercise?	_____	_____	12. - Have you ever had a sprain, strain, or swelling after injury?	_____	_____
- Have you ever been dizzy during or after exercise?	_____	_____	- Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	_____	_____
- Have you ever had chest pain during or after exercise?	_____	_____	- If yes, check and explain below:		
- Do you get tired more quickly than your friends during exercise?	_____	_____	___ Head ___ Elbow ___ Hip		
- Have you ever had racing of your heart or skipped heartbeats?	_____	_____	___ Neck ___ Forearm ___ Thigh		
- Have you had high blood pressure or high cholesterol?	_____	_____	___ Back ___ Wrist ___ Knee		
- Have you ever been told you have a heart murmur?	_____	_____	___ Chest ___ Hand ___ Shin/calf		
- Has any family member or relative died of heart problems or of sudden death before age 50?	_____	_____	___ Shoulder ___ Finger ___ Ankle		
- Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	_____	_____	___ Upper arm ___ Foot ___ Other		
- Has a physician ever denied or restricted your participation in sports for any heart problem?	_____	_____	Explain "Yes" answers here: _____		
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	_____	_____	_____		
7. - Have you ever had a head injury or concussion?	_____	_____	_____		
- Have you ever been knocked out, become unconscious, or lost your memory?	_____	_____	_____		
- Have you ever had a seizure?	_____	_____	_____		
- Do you have frequent or severe headaches?	_____	_____	_____		
- Have you ever had numbness or tingling in your arms, hands, legs, or feet?	_____	_____	_____		
- Have you ever had a stinger, burner, or pinched nerve?	_____	_____	_____		
8. Have you ever become ill from exercising in the heat?	_____	_____	_____		

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Parents: I hereby give my consent for my child to compete in rowing events and participate in activities for River City Rowing Club Junior Crew.

Signature of Athlete _____ Signature of Parent _____ Date _____

River City Rowing Club Junior Crew

Physical Examination

Preparticipation Physical Examination

Date of Exam _____

Name _____		Age _____	Date of Birth _____
Height _____	Weight _____	% Body fat (optional) _____	Pulse _____ BP ____/____ (____/____,____,____)
Vision R 20/____	L 20/____	Corrected: Y N	Pupils: Equal _____ Unequal _____

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearances			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/Ankle			
Foot			

* Station-based exam only

CLEARANCE

____ Cleared

____ Cleared after completing evaluation/rehabilitation for: _____

____ Not cleared for: _____ Reason: _____

Recommendation: _____

Name of physician (print/type) _____

Address _____

Signature of physician _____, MD or DO