

**THE SOUTH CAROLINA INDEPENDENT SCHOOL ASSOCIATION
Pre-Participation History & Health Assessment**

Name RYAN APJJOPCC Date of Birth: 07/31/1993 Grade: _____

School: _____ Sex: F M Sports: _____

Address: 4FWJSEOXFJWYZSUOVDPDR675 DOYLESTOWN, PA 18901 Phone: 215-341-1531

Personal Physician: S Kressly, MD Phone: 215-343-5520

In Case of an Emergency Contact: _____ Relationship: _____

Home Phone #: _____ Cell #: 215-373-1275 Other: _____

Attention parent or guardian and athlete: answers to the following questions are very important! Please take the time to answer each question to the best of your knowledge.

General Medical History:

- | | Yes | No |
|--|-------|-------|
| 1. Do you have asthma? | _____ | _____ |
| 2. Do you have diabetes? | _____ | _____ |
| 3. Do you have high blood pressure? | _____ | _____ |
| 4. Do you have seizures? | _____ | _____ |
| 5. Do you have sickle cell trait? | _____ | _____ |
| 6. Do you have any other major medical problems? | _____ | _____ |
| 7. Have you ever been hospitalized or had surgery? | _____ | _____ |
| 8. Do you cough, wheeze or have trouble breathing
with exercise? | _____ | _____ |
| 9. Do you use an inhaler? | _____ | _____ |
| 10. Do you have a single organ, testicle or kidney? | _____ | _____ |
| 11. Are you currently taking any medicines on
a regular basis (prescription or over-the-counter)? | _____ | _____ |
| 12. Have you ever taken supplements or vitamins
to help with weight loss, weight gain or improve
performance? | _____ | _____ |
| 13. Do you have any allergies (seasonal, insects,
Food, latex or medicines)? | _____ | _____ |
| 14. Have you ever had a rash or hives develop
during or after exercise? | _____ | _____ |
| 15. Do you have a skin problem other than acne? | _____ | _____ |
| 16. Have you ever had a head injury, been knocked
out, lost your memory, had your "bell rung" or
a concussion? | _____ | _____ |
| 17. Have you ever had numbness or tingling in your
arms, hands, legs, or feet? | _____ | _____ |
| 18. Have you had a stinger, burner or pinched nerve? | _____ | _____ |
| 19. Have you ever become ill from exercising in
the heat? | _____ | _____ |
| 20. Have you had mononucleosis or any significant
illness in the last 60 days? | _____ | _____ |
| 21. Do you have trouble with your eyes/wear glasses? | _____ | _____ |
| 22. Do you have trouble with your hearing/wear
hearing aids? | _____ | _____ |

General Medical History:

- | | Yes | No |
|--|-------|-------|
| 23. Do you want to weigh more/less than you do now? | _____ | _____ |
| 24. Do you lose weight regularly to meet weight
requirements for your sport or other reasons? | _____ | _____ |
| 25. Do you feel stressed out, tired or depressed? | _____ | _____ |
| 26. Are there any issues that you would like to discuss
with the doctor? | _____ | _____ |
| 27. Are your immunizations up to date? | _____ | _____ |

Females Only

- | | | |
|---|-------|-------|
| 28. Are your periods regular (every month)? | _____ | _____ |
| 29. Are your periods heavy? | _____ | _____ |

Cardiac History

- | | | |
|---|-------|-------|
| 1. Have you ever passed out during or after exercise? | _____ | _____ |
| 2. Have you ever been dizzy during or after exercise? | _____ | _____ |
| 3. Have you ever had chest pains or chest pressure
during or after exercise? | _____ | _____ |
| 4. Do you tire easily or more quickly than your
friends during exercise? | _____ | _____ |
| 5. Have you ever had racing of your heart or skipped
heartbeats? | _____ | _____ |
| 6. Have you been told you had a heart murmur? | _____ | _____ |
| 7. Have you ever been told that you had an enlarged
or weak heart? | _____ | _____ |
| 8. Has any member of your family:
Died of heart problems or sudden death before age 50? .. | _____ | _____ |
| Been told they had a serious heart problem before age 50? | _____ | _____ |
| Been told they had Marfan Syndrome? | _____ | _____ |
| 9. Has a physician ever restricted your participation in
sports? | _____ | _____ |

Orthopedic History

- | | | |
|--|-------|-------|
| 1. Have you ever broken or fractured any bones? | _____ | _____ |
| 2. Have you ever dislocated any joint? | _____ | _____ |
| 3. List any other problems with neck, spine, back, shoulders, elbows,
wrists, hands, fingers, hips, knees, ankles, feet or toes | _____ | _____ |

Explain "Yes" Answers on another page (put date of injury if known)

Parent's Permission & Acknowledgement of Risk for Son or Daughter to Participate in Athletics

As the parent or legal guardian of the above named student athlete, I give my permission for his/her participation in athletic events and the physical evaluation for that participation. I understand that this is simply a screening evaluation and not a substitute for regular health care. I also grant permission for treatment deemed necessary for a condition arising during participation in these events, including medical or surgical treatment that is recommended by a medical doctor. I grant permission to nurses, trainers, coaches, doctors or those under their direction who are part of the athletic injury prevention or treatment, to have access to necessary medical information. I know that the risk of injury to my child/ward comes with participation in sports and during travel to and from play and practice. My signature indicates that to the best of my knowledge, my answers to the above questions are complete and current.

Signature of athlete _____ Date _____

Signature of parent/guardian _____ Date _____

SOUTH CAROLINA INDEPENDENT SCHOOL ASSOCIATION

Medical Examination Form

Please Print

APJJOPCC RYAN M 07/31/1993
 Last Name First Name Middle Initial Date of Birth

Gender: Male SS# _____ Age: 27 Grade: _____

PHYSICAL EXAM - To Be Completed By Physician

Height 67.6 in Weight 146 lbs Pulse 62 Blood Pressure 98/58

	Normal	Abnormal Findings	Initials
1. Eyes (vision)	ü		
2. Ears, Nose, Throat	ü		
3. Mouth & Teeth	ü		
4. Neck	ü		
5. Cardiovascular			
6. Abdomen	ü		
7. Chest & Lungs	ü		
8. Skin	ü		
9. Genitalia-Hernia (male)	ü		
10. Musculoskeletal: ROM, strength, etc.			
• Neck	ü		
• Spine			
• Shoulders			
• Arms/hands			
• Hips		ü	
• Thighs			
• Knees			
• Ankles			
11. Neuromuscular			

Cleared without restriction
 Cleared, with recommendations for further evaluation or treatment for: _____

 Not Cleared: All Sports Certain Sports: _____

I certify that I have examined this athlete on this date and found him/her medically qualified to participate in sports. I also certify that I am a licensed physician.

Physician's Signature: Swann Kresaly DMB Date: 03/25/2021

Physician's Address: 1432 Easton Rd, Ste 3-G, Warrington, PA 18976