

# LOYOLA ACADEMY

## **Sophomore | Junior | Senior Athlete Pre-participation Forms**

### **Instructions:**

In an attempt to facilitate the process of having your son or daughter cleared for athletic participation, we have made all necessary forms available to you through this document. It is mandatory that your child has their pre-participation physical examination (PPE) completed prior to any athletic activity through Loyola Academy. The PPE should be performed well in advance of the beginning of the sport season (at least 4-6 weeks), allowing sufficient time for identification, further follow-up and appropriate resolutions of any problem conditions before participation commences. You are welcome to use the M.D., D.O., NP or P.A. of your choice; however, please keep in mind that Dr. Cherise Russo, our Team Physician, will be offering a discounted rate of \$40.00 for Loyola athletes at her new office at Northwestern Orthopedic Institute in Glenview through the month of June. Regardless of which doctor you choose to conduct your physical, we need you to use all of the forms provided in this document. Details of the physicals set up through Loyola Academy and Northwestern Orthopedic Institute will be mailed to your home in the late spring.

1. Complete and sign the Medical History and Nutritional Assessment forms and bring them with you to your physical exam.
2. Complete the Physical Examination with your healthcare provider (M.D., N.P., D.O. or P.A.)
3. Sign the Parent Permission Form
4. Bring all completed forms to the Athletic Office prior to the start of your athletic season.



### **Questions?**

Contact our Athletic Office at 847.920.2493.

# Part I: Medical History

Date of Exam \_\_\_\_\_

Note: Please explain any "Yes" responses in the space at the lower right. Circle questions to which you do not know the answer.

Name \_\_\_\_\_ Gender \_\_\_\_\_ Loyola ID \_\_\_\_\_  
 Age \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Grade \_\_\_\_\_ School Loyola Academy  
 Sport(s) \_\_\_\_\_ Physician \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_

*In case of emergency, contact:*

Name \_\_\_\_\_ Relation \_\_\_\_\_ Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 1. Have you had a medical illness or injury since your last check up or sports physical?<br>Do you have a chronic illness?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you been hospitalized overnight?<br>Have you ever had surgery?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently taking any prescription or nonprescription (over the counter) medications or pills or using an inhaler?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever passed out during or after exercise?<br>Have you ever been dizzy during or after exercise?<br>Have you ever had racing of your heart or skipped heartbeats?<br>Have you been told you have a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has any family member or relative died of heart problems or of sudden death before age 50?<br>Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Has a physician ever denied or restricted your participation in sports for any heart problems?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever had a head injury or concussion?<br>Have you ever been knocked out, become unconscious, or lost your memory?<br>Have you ever had a seizure?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had numbness or tingling in your arms, hands, legs, or feet?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever become ill from exercising in the heat?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you cough, wheeze, or have trouble breathing during or after activity?<br>Do you have asthma?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you use any special protective or corrective equipment that isn't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?          | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you had any problems with your eyes or vision? Do you wear glasses, contacts or protective eyewear?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever had a sprain, strain, or swelling after injury?<br>Have you broken any bones or dislocated any joints?<br>Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?    | <input type="checkbox"/> | <input type="checkbox"/> |

**Continued from #11.**

If yes to the previous questions, check appropriate box and explain below.

- |                                    |                                  |                                    |
|------------------------------------|----------------------------------|------------------------------------|
| <input type="checkbox"/> Head      | <input type="checkbox"/> Elbow   | <input type="checkbox"/> Hip       |
| <input type="checkbox"/> Neck      | <input type="checkbox"/> Forearm | <input type="checkbox"/> Thigh     |
| <input type="checkbox"/> Back      | <input type="checkbox"/> Wrist   | <input type="checkbox"/> Knee      |
| <input type="checkbox"/> Chest     | <input type="checkbox"/> Hand    | <input type="checkbox"/> Shin/calf |
| <input type="checkbox"/> Shoulder  | <input type="checkbox"/> Finger  | <input type="checkbox"/> Ankle     |
| <input type="checkbox"/> Upper Arm | <input type="checkbox"/> Foot    | <input type="checkbox"/>           |

Date of your last tetanus booster: \_\_\_\_\_

Explain any "Yes" responses below.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
athlete signature

\_\_\_\_\_  
parent signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
date

## Part II: Nutritional Assessment Form

### Female Student

Name \_\_\_\_\_ ID# \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

Please answer the following questions to the best of your ability.

How old were you when you had your first menstrual period? \_\_\_\_\_

How often do you have a menstrual period? \_\_\_\_\_

How many periods have you had in the last twelve months? \_\_\_\_\_

Are you taking any medication that would induce your monthly period? \_\_\_\_\_

If yes, please list medication. \_\_\_\_\_

Are you currently taking any dietary supplements? \_\_\_\_\_

If yes, please list the names of the supplements. \_\_\_\_\_

How many meals do you eat each day? \_\_\_\_\_

Do you often skip meals? \_\_\_\_\_

Have you ever been on a diet? \_\_\_\_\_

What is your present weight? \_\_\_\_\_

Are you happy with this weight? \_\_\_\_\_ If no, what weight would you like to be? \_\_\_\_\_

Have you ever tried to lose weight with (check all that applies):

Vomiting \_\_\_\_\_ Laxatives \_\_\_\_\_ Water Pills \_\_\_\_\_ Diet Pills \_\_\_\_\_

Do you think about what to eat or your body weight more than you want to? \_\_\_\_\_

Are thoughts about your weight or body causing you to be excessively sad or nervous? \_\_\_\_\_

Have you ever been diagnosed with a disordered eating problem? \_\_\_\_\_

Would you like to discuss your eating patterns with a trained professional? \_\_\_\_\_

PHYSICIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

### Male Student

Name \_\_\_\_\_ ID# \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

Please answer the following questions to the best of your ability.

How many meals do you eat each day? \_\_\_\_\_

Are there certain foods that you do not eat? \_\_\_\_\_

What is your present weight? \_\_\_\_\_

Are you happy with this weight? \_\_\_\_\_ If no, what weight would you like to be? \_\_\_\_\_

Have you ever tried to lose weight with (check all that applies):

Vomiting \_\_\_\_\_ Laxatives \_\_\_\_\_ Water Pills \_\_\_\_\_ Diet Pills \_\_\_\_\_

Are you currently taking any dietary supplements? \_\_\_\_\_

If yes, please list the names of the supplements. \_\_\_\_\_

Have you ever been diagnosed with a disordered eating problem? \_\_\_\_\_

Would you like to discuss your eating patterns with a trained professional? \_\_\_\_\_

PHYSICIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

### Part III: Physical Evaluation

Name \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ % Body fat (optional) \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_/\_\_\_\_\_(\_\_\_\_/\_\_\_\_,\_\_\_\_/\_\_\_\_)

Vision R 20/\_\_\_\_ L 20/\_\_\_\_ Corrected Y N Pupils: Equal \_\_\_\_ Unequal \_\_\_\_

	Normal	Medical	Abnormal Findings	Initials
Appearance				
Eyes/Ears/Nose/Throat				
Lymph Nodes				
Heart				
Pulses				
Lungs				
Abdomen				
Genitalia (males only)				
Skin				
Musculoskeletal				
Neck				
Back				
Shoulder/Arm				
Elbow/Forearm				
Wrist/Hand				
Hip/Thigh				
Knee				
Leg/Ankle				
Foot				

**Clearance**

Cleared

Cleared after completing evaluation/rehabilitation for \_\_\_\_\_

\_\_\_\_\_

Not cleared for: \_\_\_\_\_

Reason \_\_\_\_\_

Recommendation \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name of Physician (please print) \_\_\_\_\_ Date: \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of Physician/Physician's Assistant/Advanced Practice Nurse \_\_\_\_\_

