

Preparticipation Physical Evaluation

HISTORY FORM

Date of Exam _____

Name _____ Sex _____ Age _____ Date of birth _____

Grade _____ School _____ Sport(s) _____

Address _____ Phone _____

Personal Physician _____

In case of emergency, contact:

Name _____ Relationship _____ Phone (H) _____ Phone (W) _____

**Explain "Yes" answers below.
Circle questions you don't know the answers to.**

- | | Yes | No | | | | | |
|---|--------------------------|--------------------------|-----------|-------|------------|---------------|------------|
| 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 condition (like diabetes or asthma)? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| 3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| 4. Do you have allergies to medicines, pollens, foods, or stinging insects? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| 5. Have you ever passed out or nearly passed out DURING exercise? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| 6. Have you ever passed out or nearly passed out AFTER exercise? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| 7. Have you ever had discomfort, pain, or pressure in your chest during exercise? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| 8. Does your heart race or skip beats during exercise? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| 9. Has a doctor ever told you that you have (check all that apply): <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection | | | | | | | |
| 10. Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram) | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| 11. Has anyone in your family died for no apparent reason? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| 12. Does anyone in your family have a heart problem? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| 13. Has any family member or relative died of heart problems or of sudden death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| 14. Does anyone in your family have Marfan syndrome? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| 15. Have you ever spent the night in a hospital? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| 16. Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| 17. 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"/> | <input type="checkbox"/> | | | | | |
| 18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below: | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| 19. 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: | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| Head | Neck | Shoulder | Upper Arm | Elbow | Forearm | Hand/ Fingers | Chest |
| Upper Back | Lower Back | Hip | Thigh | Knee | Calf/ Shin | Ankle | Foot/ Toes |
| 20. Have you ever had a stress fracture? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| 21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| 22. Do you regularly use a brace or assistive device? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| 23. Has a doctor ever told you that you have asthma or allergies? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |

- | | Yes | No |
|--|--------------------------|--------------------------|
| 24. Do you cough, wheeze, or have difficulty breathing during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Is there anyone in your family who has asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Have you ever used an inhaler or taken asthma medicine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Have you had infectious mononucleosis (mono) within the last month? | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Do you have any rashes, pressure sores, or other skin problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Have you had a herpes skin infection? | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Have you ever had a head injury or concussion? | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Have you been hit in the head and been confused or lost your memory? | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Do you have headaches with exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. Have you ever been unable to move your arms or legs after being hit or falling? | <input type="checkbox"/> | <input type="checkbox"/> |
| 37. When exercising in the heat, do you have severe muscle cramps or become ill? | <input type="checkbox"/> | <input type="checkbox"/> |
| 38. 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"/> |
| 39. Have you had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 40. Do you wear glasses or contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 41. Do you wear protective eyewear, such as goggles or a face shield? | <input type="checkbox"/> | <input type="checkbox"/> |
| 42. Are you happy with your weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 43. Are you trying to gain or lose weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 44. Has anyone recommended you change your weight or eating habits? | <input type="checkbox"/> | <input type="checkbox"/> |
| 45. Do you limit or carefully control what you eat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 46. Do you have any concerns that you would like to discuss with a doctor? | <input type="checkbox"/> | <input type="checkbox"/> |
| FEMALES ONLY | | |
| 47. Have you ever had a menstrual period? | <input type="checkbox"/> | <input type="checkbox"/> |
| 48. How old were you when you had your first menstrual period? _____ | | |
| 49. How many periods have you had in the last 12 months? _____ | | |
- Explain "Yes" answers here:** _____

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

Signature of Athlete _____ Signature of Parent/Guardian _____ Date _____

**UNITED STATES GYMNASTICS FEDERATION
D/B/A USA GYMNASTICS
AUTHORIZATION FORM**

Purpose: This form is used to authorize United States Gymnastics Federation d/b/a USA Gymnastics ("USAG") to disclose your protected health information as described below. Your authorization does not limit your right to choose your own physician for your own personal medical needs.

NOTE: Please Print. All information must be completed.

SECTION A: Athlete Information.

First Name: _____ M.I. _____ Last Name: _____

Date of Birth: _____ Social Security/ID Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ E-mail: _____
(optional)

SECTION B: Parent/Guardian Information. (For any athlete who is under the age of 18)

Name: _____

Relationship to Athlete: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: _____ E-mail: _____
(optional)

SECTION C: The use and disclosure being authorized.

Protected health information to be used and/or disclosed: The protected health information to be used or disclosed by USAG includes any and all health information related to the athlete's physical fitness, eligibility or ability to engage in any USAG sponsored or conducted practice, competition or exhibition.

Purpose of this Authorization/Entities Authorized to Use or Disclose: By signing this form, you authorize USAG to use or to disclose your protected health information to (1) USAG coaches, athletic trainers, and staff; (2) health care providers and their physicians, nurses, athletic trainers and staff; and (3) health care providers, athletic trainers and student trainees providing medical care at any location hosting or sponsoring sporting events in which the athlete participates. Your protected health information may be used by or disclosed to these individuals and entities for the following purposes.

- To enable USAG to obtain a determination that the athlete is fit and eligible to practice and participate in any USAG activity.
- To arrange for the diagnosis and treatment of the athlete's injuries and other medical conditions occurring during or relating to any USAG activity.
- To conduct drug testing and to report testing results as required by USAG or the United States Olympic Committee.

Media and Parents/Family Members: In addition to the foregoing, by signing this form, you authorize USAG to release protected health information to Outside Media Sources, Insurance Companies, and your parents/guardians and family members (Note: For athletes of minority age, disclosures may be made even if this line is not initialed.)

Conditions: This authorization is voluntary. However, USAG reserves the right to limit your participation in a USAG-related activity if you do not sign this Authorization. Similarly, if you sign this Authorization and later revoke it, you may no longer be permitted to participate in a USAG-related activity.

Effect of Granting this Authorization: USAG is not covered by federal health information privacy laws, such as HIPAA and FERPA. The protected health information described above may be disclosed to and/or received by individuals or organizations that also are not subject to federal health information privacy laws. As a result, if such information was previously protected, it may no longer be protected by federal health information privacy laws.

SECTION D: Expiration and revocation.

Expiration: This authorization will expire (a) one year from the date set forth below or (b) upon revocation of this authorization as described below.

Right to Revoke: You may revoke this authorization at any time by giving written notice of revocation to the contact listed below. Revocation may affect your eligibility to participate in USAG-related activities. Revocation of this authorization will *not* affect any action we took in reliance on this authorization before we received your written notice of revocation.

Contact Information: Program Director
USAG
201 South Capitol Avenue, Suite 300
Indianapolis, IN 46204

Telephone: (317) 237-5050

SIGNATURES.

Date: _____

Athlete's Signature: _____

Athlete's Name (Printed): _____

FOR ATHLETES UNDER THE AGE OF 18.

Date: _____

Parent/Legal Guardian Signature: _____

Parent/Legal Guardian Name (Printed): _____

Date: _____

Parent/Legal Guardian Signature: _____

Parent/Legal Guardian Name (Printed): _____



Authorization to Obtain and Disclose Information

I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance, or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency or employer having information available as to diagnosis, medical treatment of me, or my minor children if signed by a parent/guardian, and any other non-medical information of me or my minor children to give any and all such information to American Specialty Insurance Services, Inc. or its local representative.

I UNDERSTAND the information obtained by use of the Authorization will be used by American Specialty Insurance Services, Inc. to determine eligibility for benefits under an existing policy. Any information obtained will not be released by USA Gymnastics or American Specialty Insurance Services, Inc. to any person or organization EXCEPT to reinsuring companies, the Medical Information Bureau, Inc., or other person or organizations performing business or legal services in connection with my claim or as may be otherwise lawfully required or as I may further authorize.

I KNOW that I am entitled, upon receipt, to receive a copy of this Authorization and I am also entitled to receive it through my authorized representative.

I AGREE that a photographic copy of the Authorization shall be as valid as the original.

I AGREE the Authorization shall be valid for the term of the coverage of my, or my minor child's, policy/certificate related to the claim information sought.

Date: _____

Signatures:

Name of Minor Child/Patient

Insured/Patient (if not a Minor)

Parent/Guardian
(If insured Patient is a minor)

If a copy of this Authorization requested by Insured / Patient or Parent / Guardian, complete the following statement:

A true copy of this Authorization furnished:

Date

Agent / Claim Representative



International / National Event Consent to Treatment

If under the age of 18:

We, the undersigned, parents of _____, minor, do hereby consent to any x-ray examination, anesthetic, medical or surgical evaluation, diagnosis, or treatment that may be rendered to said minor under the general or specific instructions or the USA Gymnastics medical personnel, whether such diagnosis or treatment is rendered at a licensed hospital, clinic, or doctor's office.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required, but is given to provide authority and power to render care which the staff of USA Gymnastics in the exercise of their best judgement may deem advisable.

It is understood that in case of an emergency that reasonable efforts shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

This consent shall remain effective until one year from the date below unless sooner revoked in writing and delivered to USA Gymnastics, 201 S. Capitol Ave., Suite 300, Indianapolis, Indiana 46225.

Dated: _____

Signatures:

Mother: _____ Phone: _____

Father: _____ Phone: _____

Legal Guardian (if applicable)

_____ Phone: _____