



Orchard Pediatrics, P.C.

Newborn through Adolescent Care

Amy D. Dunn, M.D. • Sarah E. Clune, D.O. • Beth L. Nadis, M.D. • Laurie K. Fisher, M.D. • Rhonda M. Elton, M.D. • Seth A. Faber, M.D.

Athlete School Sports Participation Examination

Name _____ Sex _____ Age _____ Date of Birth _____

Grade _____ School _____ Sport(s) _____

Please review all questions and answer them to the best of your ability.

	YES	NO	DON'T KNOW
Have you ever passed out during exercise or stopped exercising because of dizziness or chest pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have asthma (wheezing), hay fever or coughing spells during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any episodes of shortness of breath, palpitations, history of rheumatic fever or unusual fatigability?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you lose weight regularly to meet the requirements for your sport?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have anything to discuss with the physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you cough, wheeze, or have trouble breathing during or after activity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FEMALES ONLY

When was your first menstrual period? _____

When was your most recent menstrual period? _____

What was the longest time between menstrual periods in the last year? _____

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

Signature of athlete

Signature parent / guardian

Date