Pre-Participation Screening Form for Student-Athletes

American International College | Dexter Health Services | 1000 State Street, Box 55, Springfield, MA 01109 | Phone 413.205.3248 | Fax 413.205.3512

Student's Name: _____ Date of birth: ____/____/____ Gender: _____Sport(s): _____

Check each box. Explain "Yes" answers below. *Further documentation may be requested by the athletic trainer or team physician.*	**Yes**	**No**
Has a provider ever denied or restricted your participation in sports for any reason?	☐	☐
Do you have any ongoing medical issues or recent illness?	☐	☐
Have you had COVID-19?	☐	☐
Have you ever passed out or nearly passed out during or after exercise?	☐	☐
Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	☐	☐
Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?	☐	☐
Has a doctor ever told you that you have any heart problems?	☐	☐
Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiogram?	☐	☐
Do you get light-headed or dizzy during exercise?	☐	☐
Have you ever had a seizure?	☐	☐
Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?	☐	☐
Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?	☐	☐
Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?	☐	☐
Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?	☐	☐
Do you have a bone, muscle, ligament, or joint injury that bothers you?	☐	☐
Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐

	Yes	**No**
Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?	☐	☐
Do you have groin or testicle pain or a painful bulge or hernia in the groin area?	☐	☐
Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?	☐	☐
Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?	☐	☐
Have you ever had numbness, tingling, or weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?	☐	☐
Have you ever become ill while exercising in the heat?	☐	☐
Do you or does someone in your family have sickle cell trait or disease?	☐	☐
Have you ever had, or do you have any problems with your eyes or vision?	☐	☐
Do you worry about your weight?	☐	☐
Are you trying to or has anyone recommended that you gain or lose weight?	☐	☐
Are you on a special diet or do you avoid certain types of foods or food groups?	☐	☐
Have you ever had an eating disorder?	☐	☐
Females/Menstruating Individuals Only		
Have you ever had a menstrual period?	☐	☐
How old were you when you had your first menstrual period?		
When was your most recent menstrual period?		
How many periods have you had in the past 12 months?		

Explain "Yes" answers here.

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

Signature of athlete (parent/guardian if under 18) _____ Date _____

The remainder of this form is to be completed by a licensed health care provider.

Provider Name: _____ Work Phone: _____

Address: _____

Street City State Zip or Postal Code Country

I have reviewed this Sports Clearance Form and have determined that the patient is:

☐ Cleared for full participation in intercollegiate sports without restrictions.

☐ Cleared for participation in intercollegiate sports with the following limitations: _____

_____

☐ Not cleared for participation in intercollegiate sports due to the following reason(s): _____

_____

Attach additional information if more space is needed. Provide return-to-play clearance note if recent major illness or injury.

Provider Signature: _____ Date: _____

Upload your completed form to your AIC Patient Portal by visiting https://aic.medicatconnect.com/