

**100 BLACK MEN OF THE BAY AREA, INC.
ATHLETIC PRE-PARTICIPATION SCREENING EXAM**

PART 1: (To be completed by **student and parents/guardian**)

Name _____ School: _____ Grade _____

Address _____

City _____ State CA Zip _____ Phone () _____

Age _____ Birth Date _____ Sex _____ Sport(s): Track & Field

Doctor's Name _____ Doctors Phone () _____

Health Insurance _____ Policy Number _____

Health History Please Circle	(Must be Completed PRIOR to the Exam) HAS THIS STUDENT HAD ANY:	Health History Please Circle	Date of Last Known Tetanus Shot _____
			IS THERE A HISTORY OF:
Y N	Hospitalizations?	Y N	Neck or back injury?
Y N	Surgery other than removal of tonsils?	Y N	Knee injury?
Y N	Missing organs (eye, kidney, testicle)?	Y N	Shoulder or elbow injury?
Y N	Allergies (medicines, insects, food)?	Y N	Ankle injury?
Y N	Chest pain or severe shortness of breath with exercise?	Y N	Dislocation of a joint?
Y N	Problems with blood pressure or heart (heart murmur)?	Y N	Catching or locking of a joint?
Y N	Dizziness or fainting with exercise?	Y N	Broken bones/fractures?
Y N	Severe or frequent headaches?	Y N	Ulcers or hernias?
Y N	Concussion or loss of consciousness?	Y N	Stingers/burners?
Y N	Heat exhaustion, heat stroke or other problems with heat?	Y N	Skin problems?
Y N	Mono, hepatitis, hemophilia?	Y N	FURTHER HISTORY:
Y N	Diabetes?	Y N	Has any family member died suddenly at less than 40 years of age of causes other than an accident?
Y N	Seizures/convulsions?	Y N	Has any family member had a heart attack at less than 55 years of age?

USE THIS SPACE TO EXPLAIN ANY YES ANSWERS TO THE ABOVE QUESTIONS.

Parent's or Guardian's Acknowledgment: I have reviewed and agree with the information presented on this form. I also understand that this examination is primarily for sports participation screening and is not intended to replace the routine health care visits as recommended by the student's personal physician. I know of no reason why the above named student should not participate and represent his or her school in supervised athletic activities.

PRINT Name of Parent/Guardian _____
Signature of Parent/Guardian

() _____ () _____ / _____
Home Phone Number Work Phone Number Date

PART 2: GENERAL EXAM (To be completed by **examining physician**)

	NORMAL	ABNORMAL (Describe)	FILL IN INFORMATION
Eyes, Ears, Nose, Throat			
Skin			
Lungs			
Heart			
Abdomen			
Genitalia/Hernia(males)			

SUGGESTED MUSCULOSKELETAL EXAM

ROM STRENGTH Normal/Abnormal (Circle One)		ROM STRENGTH Normal/Abnormal (Circle One)	
	CERVICAL/SPINE	N A	Quadriceps
N A	Flex/Ext	N A	Lumbar Spine
N A	Rotation right/left	N A	Achilles
N A	Lateral flexion right/left		
N A	Thoracic		LOWER EXTREMITY
N A	Lumbar	N A	Hip?
N A	Flex/Ext	N A	Hip Flexors/Gluteals?
N A	Rotation right/left	N A	Add/Abd-Groin/TT?
N A	Lateral flexion right/left	N A	Int./Ext. Rotation?
N A	Abdominals/Obliques	N A	Knee?
	UPPER EXTRMITY	N A	Patellar Tendon?
N A	Shoulder	N A	Tibial Tuberosity?
N A	Forward flexion/Ext	N A	MCL/LCL?
N A	Abduction/adduction	N A	ACL/PCL?
N A	Internal/Ext Rotation	N A	Cartilage Testing:
N A	Horizontal Abd/Add	N A	Quads/Hamstrings
N A	A C Joint/Clavicle	N A	Gast/Soleus Complex
N A	Stability Testing	N A	Patella
N A	Biceps flex/ext	N A	Crepitus
N A	Elbow	N A	Tracking
N A	Supination/Pronation	N A	Ankle
N A	Wrist/hand	N A	Plantar/Dorsiflexion
	GENERAL FLEXIBILITY	N A	Inversion/Eversion
N A	Hamstrings	N A	Subtalar Joint
		N A	Ligament Testing
		N A	Feet/Toes

USE THIS SPACE TO DESCRIBE ABNORMALS

DISPOSITION: Cleared for contact and non-contact sports

Conditional participation, limited to: _____

No participation until: _____

No participation in any sport or physical education because of: _____

_____/_____/_____
 Doctor's Signature / MD License # / Date