

PRE-PARTICIPATION PHYSICAL EVALUATION FORM

This side of form MUST be complete for every camp participant with Parent & Camper signature

Camp Attending (circle): Team Camp Elite Overnight Skills Camp(B&G) Skills Day Camp I & II Mini-Day Camps

Name _____ *Sex* _____ Age _____ Date of Birth _____

Address _____

Grade _____ School _____ Sport(s) _____

Personal Physician _____ Physician Phone _____

In case of emergency, contact:
Name _____ Relationship _____ Phone (H) _____ (W) _____

Explain "YES" answers below. Circle questions you do not know answers to.

	YES	NO	
1. Have you ever had a medical illness or injury since you last check up or sports physical?	<input type="checkbox"/>	<input type="checkbox"/>	11. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example: knee braces, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?
2. Have you ever been hospitalized overnight?	<input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you had any problems with your eyes or vision?
4. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
a. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	<input type="checkbox"/>	<input type="checkbox"/>	13. Do you wear glasses, contacts or protective eyewear?
5. Do you have any food allergies (for example: to pollen, medicine, food or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
6. Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	14. Have you ever had a sprain, strain or swelling after injury?
a. Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
b. Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	a. Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?
c. Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
d. Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, check appropriate box and explain below:
e. Have you had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	Head <input type="checkbox"/> Elbow <input type="checkbox"/> Hip <input type="checkbox"/>
f. Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	Neck <input type="checkbox"/> Forearm <input type="checkbox"/> Thigh <input type="checkbox"/>
g. Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	Back <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/>
h. Have you had a severe viral infection (for example: myocarditis or mononucleosis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	Chest <input type="checkbox"/> Hand <input type="checkbox"/> Shin <input type="checkbox"/>
i. Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder <input type="checkbox"/> Finger <input type="checkbox"/> Calf <input type="checkbox"/>
7. Do you have any current skin problems (for example: itching, rashes, acne, warts, fungus or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>	Arm <input type="checkbox"/> Ankle <input type="checkbox"/> Foot <input type="checkbox"/>
8. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	15. Record the dates of your most recent immunization shots for:
a. Have you ever been knocked out, become unconscious or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>	Tetanus _____ Measles _____
b. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B _____ Chicken Pox _____
c. Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	16. Current Health Insurance Information:
d. Have you ever had numbness or tingling in your arms, hands, legs or feet?	<input type="checkbox"/>	<input type="checkbox"/>	Company: _____
e. Have you ever had a stinger, burner or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	Address: _____
9. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>	Policy #: _____
10. Do you cough, wheeze or have trouble breathing during or after activity?	<input type="checkbox"/>	<input type="checkbox"/>	In Name Of: _____
a. Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>	Send Claim To: _____ Phone: _____
b. Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>	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 _____

Sign. of Parent/Guardian _____

Date _____

DIG IT UP SPORTS, INC. VOLLEYBALL CAMPS CAMPER PHYSICAL FORM

Name _____ Date of Birth _____

Height _____ Weight _____ Pulse _____ BP (_____ / _____ : _____ / _____)

Vision R 20/____ L 20/____ Corrected: Y __ N __ Pupils: Equal ____ Unequal ____ Date of Exam _____

	NORMAL	ABNORMAL FINDINGS
<i>Appearance</i>		
<i>Eyes/Ears/Nose/Throat</i>		
<i>Lymph Nodes</i>		
<i>Heart</i>		
<i>Pulses</i>		
<i>Lungs</i>		
<i>Abdomen</i>		
<i>Genitalia (males only)</i>		
<i>Skin</i>		
<i>Neck</i>		
<i>Back</i>		
<i>Shoulder/Arm</i>		
<i>Elbow/Forearm</i>		
<i>Wrist/Hand</i>		
<i>Hip/Thigh</i>		
<i>Knee</i>		
<i>Leg/Ankle/Foot</i>		

CLEARANCE

- Cleared
- Cleared after completing evaluation/rehabilitation for: _____
- _____
- _____

- Not cleared for: _____ Reason: _____
- Recommendations: _____
- _____
- _____

Name of Physician (print/type) : _____ Date: _____

Address: _____ Phone: _____

Signature of Physician: _____

***This form should be used by all campers, OR, a copy of a current school physical attached:
PHYSICIAN'S SIGNATURE REQUIRED***

Dig It Up Sports, Inc., P.O. Box 2197, Davidson, NC 28036-2197