

2011 Carolina Volleyball Camps Pre-Participation Physical Evaluation Form

This form must be complete for every camp participant with Parent & Camper signature

Full Name _____ Date of Birth _____ Grade _____

Carolina Volleyball Camp Session(s) Attending _____

Family Physician _____ Phone #: _____

In case of an emergency, contact:

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

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

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Have you ever had a medical illness or injury since your last check up or sports physical? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been hospitalized overnight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have any food allergies (for example, to pollen, medicine, food or stinging insects)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever passed out during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| a. Have you ever been dizzy during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Have you ever had chest pain during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Do you get tired more quickly than your friends do during exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Have you ever had a racing of your heart or skipped heart beats? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Have you had high blood pressure or high cholesterol? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Have you ever been told you have a heart murmur? | <input type="checkbox"/> | <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"/> |
| h. Have you had a severe viral infection (for ex myocarditis or mononucleosis) within the last month? | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Has a physician ever denied or restricted your participation in sports for heart problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have any current skin problems (for ex itching, rashes, acne, warts, fungus or blisters) | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had a head injury or concussion? | <input type="checkbox"/> | <input type="checkbox"/> |
| a. Have you ever been knocked out, become unconscious or lost memory? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Do you have frequent or severe headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Have you ever had numbness or tingling in your arms, hands, legs or feet? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Have you ever had a stinger, burner or pinched nerve? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Have you ever become ill from exercising in the heat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you cough, wheeze or have trouble breathing during or after activity? | <input type="checkbox"/> | <input type="checkbox"/> |
| a. Do you have asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Do you have seasonal allergies that require medical treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. 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)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever had a sprain, strain or swelling after injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| a. Have you had any other problems with pain or swelling in the muscles, tendons, bones or joints? | <input type="checkbox"/> | <input type="checkbox"/> |

If yes, check appropriate box and explain below:

- Head Neck Back Chest Shoulder Upper Arm
 Elbow Forearm Wrist Hand Finger
 Hip Thigh Knee Shin/calf Ankle Foot

Explain "Yes" answers here: _____

Current Health Insurance Information *(All campers are required to have their own medical coverage)*

Company: _____ Policy # _____

Policy Holder _____ Send claim to: _____

Address: _____ Phone #: _____

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

Signature of athlete _____ **Date** _____

Signature of parent/guardian _____ **Date** _____