Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_ Athlete Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_ Age: \_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian Name (if under 18): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Diagnosis (circle):**  Achondroplasia - Spondyloepiphyseal Dysplasia (SED) - Hypochondroplasia

Pseudoachondroplasia - Diastrophic Dysplasia - Multiple Epiphyseal Dysplasia

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications:**  Please list all of your prescription and over-the-counter medicines

Allergies: (Circle) Yes No

If yes, please identify specific allergy (circle) Medicines Pollens Food Stinging Insects

**Hospitalizations/Surgeries**:

**Medical Questions (Circle answer)**

1. Has a doctor ever denied or restricted your participation in sports for any reason? Yes No

2. Do you have any ongoing medical conditions? Yes No

3. Have you ever passed out or nearly passed out DURING or AFTER exercise? Yes No

4. Has a doctor ever ordered a test for your heart? Yes No

5. Do you get lightheaded or feel more short of breath than expected during exercise? Yes No

6. Do you have high blood pressure? Yes No

7. Have you ever had an unexplained seizure? Yes No

8. Do you cough, wheeze, or have difficulty breathing during or after exercise? Yes No

9. Do you have asthma? Yes No

10. Have you ever had a head injury or concussion? Yes No

11. Were you born without or are you missing a kidney, spleen or any other organ? Yes No

12. Do you have urinary urgency, frequency or incontinence? Yes No

13. Do any of your joints become painful, swollen, feel warm or look red? Yes No

14. Have you ever had numbness/tingling/weakness in your arms or legs? Yes No

If you answered Yes to any questions, please explain here:

Pre-participation Physical Examination Form – To Be Filled Out by Physician

Name: Date of Birth:

Height: Weight: Male: Female: BP: \_\_\_\_\_\_\_\_\_\_ Pulse:

|  |  |  |
| --- | --- | --- |
| Medical | Normal | Abnormal Findings |
| General Appearance: |  |  |
| Eyes/Ears/nose/throat |  |  |
| Lymph nodes |  |  |
| Heart/Pulses |  |  |
| Lungs |  |  |
| Abdomen |  |  |
| Skin |  |  |
| Neurologic/Reflexes/Strength |  |  |
| Back |  |  |
| Shoulder/arm |  |  |
| Elbow/arm |  |  |
| Wrist/hand/fingers |  |  |
| Lower extremities |  |  |
| Functional/Gait |  |  |
| Other |  |  |

**Special Studies:**

Cervical flexion/extension x-rays: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Cleared for all sports without restriction

\_\_\_ Cleared for all sports without restriction with recommendations for further evaluation or treatment

\_\_\_ Not cleared (circle) *For any sports For certain sports*

Reason:

I have examined the above named athlete and completed the pre-participation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above.

Name of physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Cervical spine x-rays in flexion/extension required on all dwarfs except for Achondroplasia.
* There is a predisposition to atlantoaxial instability. These are required once for an adult athlete. They are required every **three** years in juvenile/adolescent athlete. If there are clinical symptoms to suggest an issue, they will need to be repeated.

**Prior to May 31, 2018, scan and email form to registration@daaa.org or mail to:**

**Dwarf Athletic Association of America  
PO Box 2, Kentfield, CA 94914-0002.**