

**2015 Dwarf Athletic Association of America Medical Evaluation for Saint Louis, MO
Pre-participation Physical Evaluation – TO BE FILLED OUT BY ATHLETE/PARENT**

Date: _____

Name: _____ Date of Birth: _____

Sex: _____ Age: _____ Parent or Guardian (if under 18): _____

Diagnosis: ☐ Achondroplasia ☐ Spondyloepiphyseal Dysplasia (SED)

☐ Pseudoachondroplasia ☐ Diastrophic Dysplasia ☐ Hypochondroplasia

☐ Multiple Epiphyseal Dysplasia ☐ Other _____

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

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Hospitalizations/Surgeries:

Medical Questions:

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, 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: _____

EKG (over 40 yrs): _____

☐ Cleared for all sports without restriction☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment: _____☐ Not cleared☐ 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.

****EKG required for competitors over age 40**

**Prior to June 1, 2015, Mail to DAAA, 708 Gravenstein Hwy, North, #118,
Sebastopol, CA 95472**