

PRE-PARTICIPATION PHYSICAL EVALUATION

PLEASE PRINT

DATE OF EXAM _____

Name _____ Date of Birth _____

Height _____ Weight _____ Body fat (optional) _____% Pulse _____ BP _____ / _____ (_____ / _____)
Initial BP Post Exercise 5 Min. Post Exercise

Vision: R 20/ _____ L 20/ _____ Corrected Y N Pupils: Equal Unequal

MEDICAL	Normal	Abnormal Findings
Appearance		
Eyes/Ears/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia (male only)		
Skin		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		

CLEARANCE

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

- Not cleared for: _____ Reason: _____

Recommendations: _____

Name & Title of Examiner (Print/Type) _____ Date _____

Address _____ Phone _____

Signature of Examiner _____

PRE-PARTICIPATION PHYSICAL EXAM

DATE OF EXAM: _____

Name: _____ Sex: _____ Age: _____ Date of Birth: _____

Age on Sept. 1st of this year _____ Sport(s): _____

Address: _____ Phone: _____

Personal Physician: _____

In case of emergency, contact

Name _____ Relationship _____ Home Phone _____ Work Phone _____

History

This section is to be carefully completed by the student and his/her parent(s) or legal guardian(s) before participation in interscholastic athletics in order to help detect possible risks.

*Explain "YES" answers in the space provided.
Circle questions you don't know the answer to.*

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| <p>1 Has a doctor ever denied or restricted your participation in sports for any reason? Yes No</p> <p>2 Do you have an ongoing medical condition (like diabetes or asthma)? Yes No</p> <p>3 Are you currently taking any prescription or nonprescription (over-the-counter) medicine or pills? Yes No</p> <p>4 Do you have allergies to medicines, pollens, foods or stinging insects? Yes No</p> <p>5 Do you think you are in good health? Yes No</p> <p>6 Have you ever passed out or nearly passed out DURING exercise? Yes No</p> <p>7 Have you ever passed out or nearly passed out AFTER exercise? Yes No</p> <p>8 Have you ever had discomfort, pain or pressure in your chest during exercise? Yes No</p> <p>9 Does your heart race or skip beats during exercise? Yes No</p> <p>10 Has a doctor ever told you that you have (check all that apply): Yes No</p> <p style="margin-left: 20px;"><input type="checkbox"/> High Blood Pressure <input type="checkbox"/> A heart murmur</p> <p style="margin-left: 20px;"><input type="checkbox"/> High Cholesterol <input type="checkbox"/> A heart infection</p> <p>11 Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram) Yes No</p> <p>12 Has anyone in your family died for no apparent reason? Yes No</p> <p>13 Does anyone in your family have a heart problem? Yes No</p> <p>14 Has any family member or relative died of heart problems or of sudden death before age 50? Yes No</p> <p>15 Does anyone in your family have Marfan syndrome? Yes No</p> <p>16 Have you ever spent the night in a hospital? Yes No</p> <p>17 Have you ever had surgery? Yes No</p> <p>18 Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis, that caused you to miss practice or game? Yes No</p> <p style="margin-left: 20px;">If yes, circle affected area below.</p> <p>19 Have you had any broken or fractured bones or dislocated joints? Yes No</p> <p style="margin-left: 20px;">If yes, circle below.</p> <p>20 Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast or crutches? If yes, circle below. Yes No</p> | <p>25 Do you cough, wheeze, or have difficulty breathing during or after exercise? Yes No</p> <p>26 Is there anyone in your family who has asthma? Yes No</p> <p>27 Have you ever used an inhaler or taken asthma medicine? Yes No</p> <p>28 Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? Yes No</p> <p>29 Have you had infectious mononucleosis (mono) within the last month? Yes No</p> <p>30 Do you have any rashes, pressure sores or other skin problems? Yes No</p> <p>31 Have you had a herpes skin infection? Yes No</p> <p>32 Have you ever had a head injury or concussion? Yes No</p> <p>33 Have you been hit in the head and been confused or lost your memory? Yes No</p> <p>34 Have you ever had a seizure? Yes No</p> <p>35 Do you have headaches with exercise? Yes No</p> <p>36 Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? Yes No</p> <p>37 Have you ever been unable to move your arms or legs after being hit or falling? Yes No</p> <p>38 When exercising in the heat, do you have severe muscle cramps or become ill? Yes No</p> <p>39 Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? Yes No</p> <p>40 Have you had any problems with your eyes or vision? Yes No</p> <p>41 Do you wear glasses or contact lenses? Yes No</p> <p>42 Do you wear protective eyewear, such as goggles or a face shield? Yes No</p> <p>43 Are you happy with your weight? Yes No</p> <p>44 Are you trying to gain or lose weight? Yes No</p> <p>45 Has anyone recommended you change your weight or eating habits? Yes No</p> <p>46 Do you limit or carefully control what you eat? Yes No</p> <p>47 Do you have any concerns that you would like to discuss with a doctor? Yes No</p> <p style="text-align: center;">FEMALES ONLY</p> <p>48 Have you ever had a menstrual period? Yes No</p> <p>49 How old were you when you had your first menstrual period? Yes No</p> <p>50 How many periods have you had in the last 12 months? Yes No</p> |
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Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/Fingers	Chest
Upper Back	Lower Back	Hip	Thigh	Knee	Calf/Shin	Ankle	Foot/Toes

- 21** Have you ever had a stress fracture? Yes No
- 22** Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? Yes No
- 23** Do you regularly use a brace or assistive device? Yes No
- 24** Has a doctor ever told you that you have asthma or allergies? Yes No

I (we) hereby state, to the best of my (our) knowledge, my (our) answers to the above questions are complete and correct.

Signature: _____ Date: _____

Athlete/Parent or Guardian

The student has family insurance Yes No; If yes, family insurance company name and policy number. _____

NOTE: CONSENT AND HIPAA RELEASE FORMS THAT MUST BE SIGNED BY BOTH THE PARENT AND THE STUDENT ARE ON A SEPARATE SHEET.
NOTE: HIST ORY AND ALL CONSENT FORMS MUST BE COMPLETED PRIOR TO PHYSICAL EXAMINATION.