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.

Yes No

- ○ ○ 1. Has a doctor ever denied or restricted your participation in sports for any reason?
- ○ ○ 2. Do you have an ongoing medical condition (like diabetes or asthma)?
- ○ ○ 3. Are you currently taking any prescription or nonprescription (over-the-counter) medicine or pills?
- ○ ○ 4. Do you have allergies to medicines, pollens, foods or stinging insects?
- ○ ○ 5. Do you think you are in good health?
- ○ ○ 6. Have you ever passed out or nearly passed out DURING exercise?
- ○ ○ 7. Have you ever passed out or nearly passed out AFTER exercise?
- ○ ○ 8. Have you ever had discomfort, pain or pressure in your chest during exercise?
- ○ ○ 9. Does your heart race or skip beats during exercise?
- ○ ○ 10. Has a doctor ever told you that you have (check all that apply): High Blood Pressure • High Cholesterol • A heart murmur • A heart infection
- ○ ○ 11. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)
- ○ ○ 12. Has anyone in your family died for no apparent reason?
- ○ ○ 13. Does anyone in your family have a heart problem?
- ○ ○ 14. Has any family member or relative died of heart problems or of sudden death before age 50?
- ○ ○ 15. Does anyone in your family have Marfan syndrome?
- ○ ○ 16. Have you ever spent the night in a hospital?
- ○ ○ 17. Have you ever had surgery?
- ○ ○ 18. Have you ever had an injury, like sprain, muscles, ligament tear, or tendonitis, that caused you to miss practice or game? If yes, circle affected area below.
- ○ ○ 19. Have you had any broken or fractured bons or dislocated joints? If yes, circle below.
- ○ ○ 20. Have you had a bone or joint injury that requird x-rays, MRI, CT, surgery, injections, rehabilition, physical therapy, a brace, a cast or crutches? If yes, circle below.

  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?
- ○ ○ 22. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?
- ○ ○ 23. Do you regularly use a brace or assistive device?
- ○ ○ 24. Has a doctor ever told you that you have asthma or allergies?
- ○ ○ 25. Do you cough, wheeze. or have difficulty breathing during or after exercise?
- ○ ○ 26. Is there anyone in your family who has asthma?
- ○ ○ 27. Have you ever used an inhaler or taken asthma medicine?
- ○ ○ 28. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?
- ○ ○ 29. Have you had infectious mononucleosis (mono) within the last month?

Yes No

- ○ ○ 30. Do you have any rashes, pressure sores or other skin problems?
- ○ ○ 31. Have you had a herpes skin infection?
- ○ ○ 32. Have you ever had a head injury or concussion?
- ○ ○ 33. Have you been hit in the head and been confused or lost your memory?
- ○ ○ 34. Have you ever had a seizure?
- ○ ○ 35. Do you have headaches with exercise?
- ○ ○ 36. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?
- ○ ○ 37. Have you ever been unable to move your arms or legs after being hit or falling?
- ○ ○ 38. When exercising in the heat, do you have severe muscle cramps or become ill?
- ○ ○ 39. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?
- ○ ○ 40. Have you had any problems with your eyes or vision?
- ○ ○ 41. Do you wear glasses or contact lenses?
- ○ ○ 42. Do you wear protective eyewear, such as goggles or a face shield?
- ○ ○ 43. Are you happy with your weight?
- ○ ○ 44. Are you trying to gain or lose weight?
- ○ ○ 45. Has anyone recommended you change your weight or eating habits?
- ○ ○ 46. Do you limit or carefully control what you eat?
- ○ ○ 47. Do you have any concerns that you would like to discuss with a doctor?

Females Only

- ○ ○ 48. Have you ever had a menstrual period?
- ○ ○ 49. How old were you when you had your first menstrual period?
- ○ ○ 50. How many periods have you had in the last 12 months?

Explain "Yes" Answers Here: (Attach additional sheets as needed.)

_____

_____

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

Signature: (Athlete/Parent or Guardian): _____ Date: _____

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:*** *HISTORY ANO ALL CONSENT FORMS MUST BE COMPLETED PRIOR TO PHYSICAL EXAMINATION.*

Modified from American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine, 2004. Rev. 4/05

Pre-Participation Physical Evaluation

Please Print

Date of Exam: _____

Name: _____ Date of Birth: _____

Height: _____ Weight: _____ [redacted]

Pulse: _____ BP (Initial BP): _____ [redacted]

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		
MUSCULOSKELET AL		
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: _____