

Preparticipation Physical Evaluation

HISTORY FORM

Date of Exam _____

Name _____ Sex _____ Age _____ Date of birth _____
 Grade _____ School _____ Sport(s) _____
 Address _____ Phone _____
 Personal Physician _____
In case of emergency, contact:
 Name _____ Relationship _____ Phone(H) _____ Phone(W) _____

**Explain "Yes" answers below.
 Circle questions to which you don't know the answers.**

- | | Yes | No | | Yes | No |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Has a doctor ever denied or restricted your participation in sports for any reason? | <input type="checkbox"/> | <input type="checkbox"/> | 24. Do you cough, wheeze, or have difficulty breathing during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have an ongoing medical condition (like diabetes or asthma)? | <input type="checkbox"/> | <input type="checkbox"/> | 25. Is there anyone in your family who has asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? | <input type="checkbox"/> | <input type="checkbox"/> | 26. Have you ever used an inhaler or taken asthma medicine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have allergies to medicines, pollens, foods or stinging insects? | <input type="checkbox"/> | <input type="checkbox"/> | 27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever passed out or nearly passed out DURING exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 28. Have you had infectious mononucleosis (mono) within the last month? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever passed out or nearly passed out AFTER exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 29. Do you have any rashes, pressure sores, or other skin problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had discomfort, pain, or pressure in your chest during exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 30. Have you had a herpes skin infection? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Does your heart race or skip beats during exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 31. Have you ever had a head injury or concussion? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Has a doctor ever told you that you have (check all that apply): | | | 32. Have you been hit in the head and been confused or lost your memory? | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> High blood pressure | | | 33. Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> High cholesterol | | | 34. Do you have headaches with exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> A heart murmur | | | 35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> A heart infection | | | 36. Have you ever been unable to move your arms or legs after being hit or falling? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram) | <input type="checkbox"/> | <input type="checkbox"/> | 37. When exercising in the heat, do you have severe muscle cramps or become ill? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Has anyone in your family died for no apparent reason? | <input type="checkbox"/> | <input type="checkbox"/> | 38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Does anyone in your family have a heart problem? | <input type="checkbox"/> | <input type="checkbox"/> | 39. Have you had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Has any family member or relative died of heart problems or of sudden death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> | 40. Do you wear glasses or contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Does anyone in your family have Marfan syndrome? | <input type="checkbox"/> | <input type="checkbox"/> | 41. Do you wear protective eyewear, such as goggles or a face shield? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever spent the night in a hospital? | <input type="checkbox"/> | <input type="checkbox"/> | 42. Are you happy with your weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | 43. Are you trying to gain or lose weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis, that caused you to miss a practice or game? If yes, circle affected area below: | <input type="checkbox"/> | <input type="checkbox"/> | 44. Has anyone recommended you change your weight or eating habits? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below: | <input type="checkbox"/> | <input type="checkbox"/> | 45. Do you limit or carefully control what you eat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. 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: | <input type="checkbox"/> | <input type="checkbox"/> | 46. Do you have any concerns that you would like to discuss with a doctor? | <input type="checkbox"/> | <input type="checkbox"/> |
| Head, upper back, neck, lower back, shoulder, hip, upper arm, thigh, elbow, Knee, forearm, calf/shin, hand/fingers, ankle, chest, foot/toes. | | | FEMALES ONLY | | |
| 20. Have you ever had a stress fracture? | <input type="checkbox"/> | <input type="checkbox"/> | 47. Have you ever had a menstrual period? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? | <input type="checkbox"/> | <input type="checkbox"/> | 48. How old were you when you had your first menstrual period? _____ | | |
| 22. Do you regularly use a brace or assistive device? | <input type="checkbox"/> | <input type="checkbox"/> | 49. How many periods have you had in the last 12 months? _____ | | |
| 23. Has a doctor ever told you that you have asthma or allergies? | <input type="checkbox"/> | <input type="checkbox"/> | Explain "Yes" answers here: _____ | | |

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

Signature of Athlete _____ Signature of Parent/Guardian _____ Date _____

Preparticipation Physical Evaluation

Last Name _____ First Name _____ Date of Birth _____ Grade _____
 Height _____ Weight _____ %Body Fat (optional) _____ Pulse _____ BP _____/_____, _____/_____
 Vision R 20/____ L 20/____ Corrected: Y N Pupils: Equal _____ Unequal _____

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)+			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

*Multiple-examiner set-up only +Having a third party present is recommended for the genitourinary examination

Notes: _____

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

Address/Facility stamp (physical will **NOT** be accepted without stamp)

Preparticipation Physical Evaluation

CLEARANCE FORM

(To be completed by physician)

Name _____ Sex _____ Age _____ Date of birth _____

- Cleared without restriction for ALL SPORTS
- Cleared without restriction for certain sports _____
- Cleared, with recommendations for further evaluation or treatment for: _____

- Not Cleared - Reason: _____

Recommendations: _____

EMERGENCY INFORMATION

Allergies _____

Other Information _____

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

Athlete's Emergency Information

Sport: _____ **Birthdate:** _____

Name: _____ Sex: M F Age: _____ Grade: _____

Address: _____ City: _____ Zip: _____

Parent's Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact (Other than parents) Name: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Insurance: _____ Policy/Member #: _____

Circle any of the following that apply: Diabetes Seizures Asthma Heart Condition Allergies

Any medications currently being taken: _____

Any allergies to medications: _____

In case of a serious injury requiring immediate attention school district employees are authorized to give first aid and obtain treatment or emergency hospital care.

Signature of Parent or Guardian: _____ Date: _____

To be completed by the **School Nurse only**

I have reviewed the PHYSICAL EXAMINATION REPORT: _____

Nurse's signature

Sport: _____ Date of Physical: _____