

## Pre-participation Physical Evaluation Grades 7-12

### PHYSICAL EXAMINATION

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ % Body fat (optional): \_\_\_\_\_ Pulse: \_\_\_\_\_ BP: \_\_\_\_/\_\_\_\_

Vision: R20/\_\_\_\_ L20/\_\_\_\_ Corrected: Y \_\_\_\_ N \_\_\_\_ Pupils: Equal \_\_\_\_ Unequal \_\_\_\_

MEDICAL	Normal	Abnormal Findings	Initials*
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulse			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
<b>MUSCULOSKELETAL</b>			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
Foot			

\*Station-based examination only

### CLEARANCE

- Cleared
- Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- Not cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_

Recommendations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### PHYSICIAN STATEMENT

My signature below indicates that the Health & History of this patient have been reviewed. The patient may participate at the above indicated level.

Name of Physician (print/type): \_\_\_\_\_ Date: \_\_\_\_\_

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

Signature of Physician: \_\_\_\_\_, MD or DO

## GRADES 7-12

### MEDICAL HISTORY

Date of Exam: \_\_\_\_\_

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

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

School: \_\_\_\_\_ Entering Grade: \_\_\_\_\_

Sport(s): \_\_\_\_\_

Personal Physician: \_\_\_\_\_

In case of emergency, contact: Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone numbers Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

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

	Yes	No		Yes	No
Have you had a medical illness or injury since your last check-up or sports physical?	<input type="checkbox"/>	<input type="checkbox"/>	Do you cough, wheeze or have trouble breathing during or after activities?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have an ongoing or chronic illness?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been hospitalized overnight?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position, for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid?	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently taking any prescription or over-the-counter medications or pills or using an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear glasses, contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any allergies to pollen, medicine, food or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a sprain, strain or swelling after injury?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a rash or hives develop during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have you broken or fractured any bones or dislocated any joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>			
Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<b>If yes, check appropriate box and explain below.</b>		
Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Head	<input type="checkbox"/> Elbow	<input type="checkbox"/> Hip
Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/> Forearm	<input type="checkbox"/> Thigh
Have you ever had high blood pressure or high Cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Back	<input type="checkbox"/> Wrist	<input type="checkbox"/> Knee
Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest	<input type="checkbox"/> Hand	<input type="checkbox"/> Shin/calf
Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Finger	<input type="checkbox"/> Ankle
Have you had a severe viral infection, for example, myocarditis or mononucleosis, within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Upper arm		<input type="checkbox"/> Foot
Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	Do you want to weigh more or less than you do now?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any current skin problems, for example, itching, rashes, acne, warts, fungus or blisters?	<input type="checkbox"/>	<input type="checkbox"/>	Do you lose weight regularly to meet weight requirements for your sport?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been knocked out, become unconscious, or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>			
Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Females Only</b>		
Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have an irregular menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had numbness or tingling in your arms, hands, legs or feet?	<input type="checkbox"/>	<input type="checkbox"/>	Explain "Yes" Answers Here: _____		
Have you ever had a stinger, burner or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
			_____		
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			_____		
			_____		

### PERMISSION AND RELEASE

I hereby state that, to the best of my knowledge, the answers to the above questions are correct. I hereby give my informed consent to allow the above named student to participate in all athletic activities in his/her school except those in which the examining physician has indicated on this form. I also give my permission for the student to accompany the team on any of its local or out of town trips via the modes of transportation necessary for such trip. I understand there is a risk of injury in participation in athletics and assume such risks by signing this form. If my son or daughter is injured during participation in athletics, necessary medical care can be instituted by physicians, athletic trainers, physical therapists, nurses, coaches or other persons trained in the care.

Parent/Guardian's Printed Name \_\_\_\_\_ Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State and Zip \_\_\_\_\_ Phone \_\_\_\_\_