

Pre-Participation Physical Evaluation

Date of the Exam: _____
 Name _____ Age _____ Sex _____

Date of Birth _____ Grade _____ Sports _____

Address _____ Phone _____

Medical History (to be completed & signed by student & parent).

Explain "yes" answers below. Circle questions you can't answer.

**Student Signature _____ Parent Signature _____ Date _____

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1) Have you had a medical illness or injury since your last check up or sports physical? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Do you have an ongoing or chronic illness? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Have you ever been hospitalized overnight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) Are you currently taking any prescription or non-prescription (over the counter) medication or pills or using an inhaler? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6) 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"/> |
| 7) Do you have any allergies (for example, to pollen, medicine, food or stinging insects)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8) Have you ever had a rash or hives develop during or after an exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9) Have you ever passed out during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10) Have you ever been dizzy during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11) Have you ever had a chest pain during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12) Do you get tired more quickly than your friends do during exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13) Have you ever had racing of your heart or skipped heartbeats? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14) Have you had high blood pressure or high cholesterol? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15) Have you ever been told that you have a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16) Have any family members or relative die of heart problems or sudden death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17) Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18) Has a physician ever denied or restricted your participation in sports for any heart problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19) Do you have any current skin problems (for example, Itching, rashes, acne, warts, fungus or blisters)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20) Have you ever had a head injury or concussion? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21) Have you ever been knocked out, become unconscious? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22) Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23) Do you have frequent or severe headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24) Have you ever had numbness or tingling in your arms, hands, legs or feet? | <input type="checkbox"/> | <input type="checkbox"/> |

- | | YES | NO | | | |
|--|--------------------------|--------------------------|--------------------------|-----------|--------------------------|
| 25) Have you ever had a stinger, burner or pinched nerve? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 26) Have you ever become ill from exercising in the heat? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 27) Do you cough, or have trouble breathing during or after an activity? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 28) Do you have asthma? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 29) Do you have seasonal allergies that require medical treatment? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 30) 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, retainer, hearing aid) | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 31) Have you ever had problems with your eyes or vision? .. | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 32) Do you wear glasses, contacts or protective eyewear? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 33) Have you ever had a sprain, strain or swelling injury? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 34) Have you broken or dislocated any bones or joints? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 35) Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| If yes, check appropriate blank and explain below: | | | | | |
| Head | <input type="checkbox"/> | Elbow | <input type="checkbox"/> | Hip | <input type="checkbox"/> |
| Neck | <input type="checkbox"/> | Forearm | <input type="checkbox"/> | Thigh | <input type="checkbox"/> |
| Back | <input type="checkbox"/> | Wrist | <input type="checkbox"/> | Knee | <input type="checkbox"/> |
| Chest | <input type="checkbox"/> | Hand | <input type="checkbox"/> | Shin/Calf | <input type="checkbox"/> |
| Shoulder | <input type="checkbox"/> | Finger | <input type="checkbox"/> | Ankle | <input type="checkbox"/> |
| Upper Arm | <input type="checkbox"/> | Foot | <input type="checkbox"/> | | |
| 36) Do you want to weigh more or less than you do? | <input type="checkbox"/> | | <input type="checkbox"/> | | |
| 37) Do you use weight regularly to meet weight requirements for your sport? | <input type="checkbox"/> | | <input type="checkbox"/> | | |
| 38) Do you feel stressed out? | <input type="checkbox"/> | | <input type="checkbox"/> | | |
| 39) Record the dates or your most recent immunization (shots) for: | | | | | |
| Tetanus: _____ | | Measles: _____ | | | |
| Hepatitis B: _____ | | Chickenpox: _____ | | | |

Females Only (OPTIONAL)

- 40) When was your first menstrual period? _____
- 41) When was your most recent menstrual period? _____
- 42) How many days do you have between the end of one period and the start of another? _____
- 43) How many periods have you had in the last year? _____
- 44) What was the longest time between periods in the last year? _____
- _____
- _____
- _____
- _____

PREPARTICIPATION PHYSICAL EVALUATION

The section below is to be completed by Physician or staff after history and consent forms are completed.

Student Name _____	Birth Date _____
Height _____	Weight _____
Pulse/B/P _____ / _____ BP _____ / _____	
Corrective Lenses: Y N	Pupils: Equal: Y N

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

CLEARANCE

- Cleared without restrictions

 - Cleared, with recommendations for further evaluation/rehabilitation for:

 - Not Cleared for: _____ REASON: _____
- Recommendations: _____
- _____

Name of Physician (PRINT) _____ Date: _____

Physician's signature: _____ Phone: _____