



2018-2019 ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

(The Parent or Guardian should fill out this form with assistance from the student athlete.)

Exam Date: _____

Name:
Home Address:
Phone:
Date of Birth:
Age:
Sex:
Grade:
School:
Sport(s):
Personal Physician:
Hospital Preference:

In case of emergency, contact:
Name:
Relationship:
Phone (Home):
(Work):
(Cell):
Name:
Relationship:
Phone (Home):
(Work):
(Cell):

Explain "Yes" answers on following page.
Circle questions you don't know the answers to.

	Y	N
1) Has a doctor ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
2) Do you have an ongoing medical condition (like diabetes or asthma)?	<input type="checkbox"/>	<input type="checkbox"/>
3) Are you currently taking any prescription or nonprescription (over-the-counter) medicines or supplements? (Please specify):	<input type="checkbox"/>	<input type="checkbox"/>
4) Do you have allergies to medicines, pollens, foods, or stinging insects? (Please specify):	<input type="checkbox"/>	<input type="checkbox"/>
5) Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
6) Has a doctor ever told you that you have (check all that apply): High Blood Pressure <input type="checkbox"/> A Heart Murmur <input type="checkbox"/> High Cholesterol <input type="checkbox"/> A Heart Infection <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7) Have you ever spent the night in the hospital?	<input type="checkbox"/>	<input type="checkbox"/>
8) Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>

* 9) Have you ever had an injury (sprain, muscle/ligament tear, tendinitis, etc.) that caused you to miss a practice or game? (If yes, circle affected area in the box below):	<input type="checkbox"/>	<input type="checkbox"/>			
*10) Have you had any broken/fractured bones or dislocated joints? (If yes, circle affected area in the box below):	<input type="checkbox"/>	<input type="checkbox"/>			
* 11) Have you had a bone/joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? (If yes, circle affected area in the box below):	<input type="checkbox"/>	<input type="checkbox"/>			
Head <input type="checkbox"/>	Neck <input type="checkbox"/>	Shoulder <input type="checkbox"/>	Upper Arm <input type="checkbox"/>	Elbow <input type="checkbox"/>	Forearm <input type="checkbox"/>
Hand/Fingers <input type="checkbox"/>	Chest <input type="checkbox"/>	Upper Back <input type="checkbox"/>	Low Back <input type="checkbox"/>	Hip <input type="checkbox"/>	Thigh <input type="checkbox"/>
	Knee <input type="checkbox"/>	Calf/Shin <input type="checkbox"/>	Ankle <input type="checkbox"/>	Foot/Toes <input type="checkbox"/>	



	Y	N
12) Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>
13) Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	<input type="checkbox"/>	<input type="checkbox"/>
14) Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>
15) Has a doctor told you that you have asthma or allergies?	<input type="checkbox"/>	<input type="checkbox"/>
16) Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
17) Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>
18) Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>
19) Were you born without, are you missing, or do you have a nonfunctioning kidney, eye, testicle or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
20) Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
21) Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
22) Have you had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
23) Have you ever had an injury to your face, head, skull or brain (including a concussion, confusion, memory loss or headache from a hit to your head, having your "bell rung" or getting "dinged")?	<input type="checkbox"/>	<input type="checkbox"/>
24) Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
25) Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
26) Have you ever had numbness, tingling, or weakness in your arms or legs after being hit, falling, stingers or burners?	<input type="checkbox"/>	<input type="checkbox"/>
27) When exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>
28) 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"/>
29) Have you ever been tested for sickle cell trait?	<input type="checkbox"/>	<input type="checkbox"/>
30) Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
31) Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
32) Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
33) Are you happy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>
34) Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
35) Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>
36) Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>
37) Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>

Females Only

	Y	N
38) Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
39) How old were you when you had your first menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
40) How many periods have you had in the last year?	<input type="checkbox"/>	<input type="checkbox"/>

Explain "Yes" Answers Here



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(The Physician should fill out this form with assistance from the Parent or Guardian.)

Student Name:

Date of Birth:

Patient History Questions: Please tell me about your child...

	Y	N
1) Has your child fainted or passed out DURING or AFTER exercise, emotion or startle?	<input type="checkbox"/>	<input type="checkbox"/>
2) Has your child ever had extreme shortness of breath during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
3) Has your child had extreme fatigue associated with exercise (different from other children)?	<input type="checkbox"/>	<input type="checkbox"/>
4) Has your child ever had discomfort, pain or pressure in his/her chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
5) Has a doctor ever ordered a test for your child's heart?	<input type="checkbox"/>	<input type="checkbox"/>
6) Has your child ever been diagnosed with an unexplained seizure disorder?	<input type="checkbox"/>	<input type="checkbox"/>
7) Has your child ever been diagnosed with exercise-induced asthma not well controlled with medication?	<input type="checkbox"/>	<input type="checkbox"/>

Family History Questions: Please tell me about any of the following in your family...

	Y	N
8) Are there any family members who had sudden, unexpected, unexplained death before age 50? (including SIDS, car accidents, drowning, or near drowning)	<input type="checkbox"/>	<input type="checkbox"/>
9) Are there any family members who died suddenly of "heart problems" before age 50?	<input type="checkbox"/>	<input type="checkbox"/>
10) Are there any family members who have unexplained fainting or seizures?	<input type="checkbox"/>	<input type="checkbox"/>
11) Are there any relatives with certain conditions, such as:	<input type="checkbox"/>	<input type="checkbox"/>
Enlarged Heart	<input type="checkbox"/>	<input type="checkbox"/>
Hypertrophic Cardiomyopathy (HCM)	<input type="checkbox"/>	<input type="checkbox"/>
Dilated Cardiomyopathy (DCM)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Rhythm problems:	<input type="checkbox"/>	<input type="checkbox"/>
Long QT Syndrome (LQTS)	<input type="checkbox"/>	<input type="checkbox"/>
Short QT Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Brugada Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT)	<input type="checkbox"/>	<input type="checkbox"/>
Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC)	<input type="checkbox"/>	<input type="checkbox"/>
Marfan Syndrome (Aortic Rupture)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack, age 50 or younger	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker or Implanted Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>
Deaf at Birth (Congenital Deafness)	<input type="checkbox"/>	<input type="checkbox"/>

Explain "Yes" Answers Here

I hereby state that, to the best of my knowledge, my answers to all of the above questions are complete and correct. Furthermore, I acknowledge and understand that my eligibility may be revoked if I have not given truthful and accurate information in response to the above questions.

Signature of athlete

Signature of parent/guardian

Date

Signature of MD/DO/ND/NMD/NP/PA-C/CCSP

Date:



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Name:	Date of Birth:
Age:	Sex:
Height:	Weight:
% Body fat (optional):	Pulse:
	BP: ___ / ___ (___ / ___ , ___ / ___)
Vision: R20/ ___ L20/ ___	Corrected: Y ___ N ___
Pupils: Equal ___ Unequal ___	

	Normal	Abnormal Findings	Initials*
Medical			
Appearance			
Eyes/Ears/Throat/Nose			
Hearing			
Lymph Nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary †			
Skin			
Musculoskeletal			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand/Fingers			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			

* Multi-examiner set-up only.

† Having a third party present is recommended for the genitourinary examination.

NOTES: _____

Cleared Without Restriction
 Not Cleared For: All Sports Certain Sports _____ Reason: _____

Recommendations: _____

Name of Physician(Print/Type): _____ Exam Date: _____

Address: _____ Phone: _____

Signature of Physician: _____, MD/DO/NP/PA-C