Preparticipation Physical Examination Form

(Please type or print)

Student's Name _____ Birth Date _____ Sex _____ Grade _____
Last First Middle

City _____ School _____ Place of Birth _____

Student's Address _____
Street City Zip Telephone

Parent(s) or Guardian(s) Name _____

Address (if different than student) _____
Street City Zip Telephone

Family Physician's Name, Address, Telephone _____

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 below. Circle questions you don't know the answer to.

	Yes	No
1. Have you had a medical illness or injury since your last checkup or sports physical?	☐	☐
Do you have an ongoing or chronic illness?	☐	☐
2. Have you ever been hospitalized overnight?	☐	☐
Have you ever had surgery?	☐	☐
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?	☐	☐
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	☐	☐
4. Do you think you are in good health?	☐	☐
5. Do you have any allergies (for example, to pollen, medicine, food, or stinging insect)?	☐	☐
6. Have you ever had a rash or hives develop during or after exercise?	☐	☐
Have you ever passed out during or after exercise?	☐	☐
Have you ever been dizzy during or after exercise?	☐	☐
Have you ever had chest pain during or after exercise?	☐	☐
Do you get tired more quickly than your friends do during exercise?	☐	☐
Have you ever had racing of your heart or skipped heartbeats?	☐	☐
Have you had high blood pressure or high cholesterol?	☐	☐
Have you ever been told you have a heart murmur?	☐	☐
Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
Is there a family history of heart problems in a close relative younger than age 50 (examples are enlarged heart, cardiomyopathy, long QT interval, abnormal EKG, abnormal heart rhythm)?	☐	☐
Have you had a severe heart infection (for example, myocarditis or pericarditis)?	☐	☐
Is there a family history of Marfan's Syndrome?	☐	☐
Has a physician ever denied or restricted your participation in sports for any heart problem?	☐	☐
7. Have you ever had a severe viral infection within the last month (for example, mononucleosis)?	☐	☐
8. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus or blisters)?	☐	☐
9. Have you ever had a head injury or concussion?	☐	☐
Have you ever been knocked out, become unconscious or lost your memory?	☐	☐
Have you ever had a seizure?	☐	☐
Do you have frequent or severe headaches?	☐	☐
Have you ever had numbness or tingling in your arms, hands, legs or feet?	☐	☐
Have you ever had a stinger, burner or pinched nerve?	☐	☐

	Yes	No
10. Have you ever become ill from exercising in the heat?	☐	☐
11. Do you cough, wheeze or have trouble breathing during or after activity?	☐	☐
Do you have asthma?	☐	☐
Do you have seasonal allergies that require medical treatment?	☐	☐
12. 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)?	☐	☐
13. Have you had any problems with your eyes or vision?	☐	☐
Do you wear glasses, contacts or protective eyewear?	☐	☐
14. Have you ever had a sprain, strain or swelling after injury?	☐	☐
Have you broken or fractured any bones or dislocated any joints?	☐	☐
Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?	☐	☐

If yes, check the appropriate box and explain below.

☐ Head ☐ Upper Arm ☐ Hand ☐ Knee
☐ Neck ☐ Elbow ☐ Finger ☐ Shin/calf
☐ Back ☐ Forearm ☐ Hip ☐ Ankle
☐ Chest ☐ Wrist ☐ Thigh ☐ Foot
☐ Shoulder

15. Do you want to weigh more or less than you do now?	☐	☐
Do you lose weight regularly to meet weight requirements for your sport?	☐	☐
16. Do you feel stressed out?	☐	☐

17. Record the dates of your most recent immunizations (shots) for:
Tetanus _____ Measles _____
Hepatitis B _____ Chickenpox _____

18. FEMALES ONLY

When was your first menstrual period? _____
When was your most recent menstrual period? _____
How much time do you usually have from the start of one period to the start of another? _____
How many periods have you had in the last year? _____
What was the longest time between periods in the last year? _____

19. ALL PARTICIPANTS

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_____

Modified from the form approved by the American Academy of Family Physicians, the American Academy of Pediatrics, the American Medical Society for Sports Medicine, the American Orthopedic Society for Sports Medicine and the American Osteopathic Academy of Sports Medicine.

Physical Examination

(Please type or print)

Student's Name _____ Birth Date _____
Last First Middle

Date of Exam _____

Height _____ Weight _____ % Body Fat (optional) _____ Pulse _____ BP _____/_____

Vision R 20/ _____ L 20/ _____ Corrected: Y N Pupils: Equal _____ Unequal _____

	Normal	Abnormal Findings	Initials*
MEDICAL			
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			

*Station-based examination only

Clearance

☐ Cleared

☐ Cleared after completing evaluation/rehabilitation for: _____

_____

_____

_____

☐ Not cleared for: _____ Reason: _____

Recommendations: _____

_____

_____

_____

I certify that I have on this date examined this student and that, on the basis of the examination requested by the school authorities and the student's medical history as furnished to me, I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities (Note exceptions above).

_____ _____

Physician's Name and Address (stamp or print)
If the Physician's Assistant (P.A.) or Advanced Nurse Practitioner (A.N.P.) performed the exam, name and address of collaborating physician or physician group:

_____

Examiner's Signature Date

_____

Examiner's Telephone Number

NOTE: History and Consent Must be Completed Prior to Physical Examination