

Pre-Participation History and Physical Examination (rev. 12/2010)

Name (print full name) _____ Birth Date _____ Pupil # _____ Exam Date _____
 Street Address _____ City _____ Zip _____
 Home Phone _____ Sport _____ Grade _____ M ☐ F ☐

Parents/Guardians must complete the reverse side before physical appointment.

MEDICAL AUTHORITIES LICENSED TO GIVE PHYSICAL EXAMINATIONS

- | | | |
|--|---|---|
| <input type="checkbox"/> Medical Doctor (MD) | <input type="checkbox"/> Certified Nurse Practitioner (CRN) | <input type="checkbox"/> Naturopaths (ND) |
| <input type="checkbox"/> Doctor of Osteopathy (DO) | <input type="checkbox"/> Medics-Physician Assistant (PA) | |

Age _____ Pulse _____ Blood Pressure _____

↓ This Section Optional ↓

Height _____ Weight _____

Urinalysis _____

Visual Acuity: Left: 20/ _____ Right: 20/ _____

Body Fat% _____

HCT _____

Normal

Abnormal

- ☐ Head
- ☐ Eyes (pupils), ENT
- ☐ Teeth
- ☐ Chest
- ☐ Lungs
- ☐ Heart
- ☐ Abdomen
- ☐ Genitalia
- ☐ Neurological
- ☐ Skin
- ☐ Physical Maturity
- ☐ Spine, Back
- ☐ Shoulders, Upper extremities
- ☐ Lower extremities

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

- Assessment** ☐ Full participation
- ☐ Limited participation (describe limitations, restrictions) _____
- ☐ Life threatening condition (severe asthma, bee/food allergy) requires medication order before participation. (Please attach the information/medication orders.)

- ☐ Participation contradicted (list reasons)

Recommendations (equipment, taping, rehabilitation, etc.)

Examiner's Certification

Authorized examiners are medical authorities licensed to give medical examinations. (WIAA 18.13.1)

I hereby certify that the above-named individual is physically qualified to participate in all interscholastic athletic activities NOT CROSSED OUT BELOW:

Baseball	Basketball	Bowling	Cheerleading	Cross Country	Drill Team	Football	Golf
Gymnastics	Soccer	Softball	Swimming	Tennis	Volleyball	Wrestling	Track

Wrestling Weight Permit: Circle lowest weight classifications permissible

Senior High	103	112	119	125	130	135	140	145	152	161	171	189	215	275
Junior High	75	80	85	90	95	100	105	110	115	120	125	130	135	140
							152	162	172	185	Unlimited (must be over 185)			

Examiner's Name (print) _____ Examiner's Phone (____) _____

Examiner's Signature _____ Date _____

Pre-Participation History

Yes No

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had any illness/injury recently, or do you have an illness/injury now? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had a medical problem, illness, or injury since your last exam? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any chronic or recurrent illness? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any illness lasting more than a week? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been hospitalized overnight? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had any surgery other than tonsillectomy? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any injuries requiring treatment by a physician? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any organ missing other than tonsils (appendix, eye, kidney, testicle, etc.)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you presently taking ANY medications (including birth control pills, vitamins, aspirin, etc.)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have ANY allergies (medicines, bees, foods, or other factors)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had chest pain, dizziness, faintness, passing out during or after exercise? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you tire more easily or quickly than your friends during exercises? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any problem with your blood pressure or your heart? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have any close relatives had heart problems, heart attack, or sudden death before they were age 50? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any skin problems (acne, itching, rashes, etc.)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had fainting, convulsions, seizures, or severe dizziness? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have frequent severe headaches? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a "stinger" or "burner" or "pinched nerve"? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been "knocked out" or "passed out"? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a neck or head injury? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had heat exhaustion, heat stroke, heat cramps, or similar heat-related problems? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had asthma, or trouble breathing, or cough during or after exercise? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you wear eyeglasses, contact lenses, or protective eye wear? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had any problems with your eyes or vision? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you wear any dental appliances such as braces, bridge, plate, retainer? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a knee injury? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had an ankle injury? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever injured any other joint (shoulder, wrist, fingers, etc.)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a broken bone (fracture)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a cast, splint, or had to use crutches? |
| <input type="checkbox"/> | <input type="checkbox"/> | Must you use special equipment for competition (pads, braces, neck roll, etc.)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Has it been more than 5 years since your last tetanus booster shot? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you worried about your weight? |
| <input type="checkbox"/> | <input type="checkbox"/> | FEMALES: Have you any menstrual problems? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you any medical concerns about participating in your sport? |

Recommendations
