Assets School

ANNUAL PHYSICAL EXAMINATION FOR ATHLETES

Student's Name (PRINT) ______________________ LAST FIRST MIDDLE INITIAL M/F ________ Date of Birth ____/____/____ MONTH DAY YEAR

Address ______________________ STREET NO. CITY STATE ZIP CODE Home Telephone __________ Grade ______

PHYSICAL EXAMINATION

Height ____________ Weight ____________ Blood Pressure ________/________ Pulse ________

Vision: Right 20/ ________ Left 20/ ________ Corrected: Yes ____ No ____ Pupils ________

Immunization ______________________

	Normal	Comment	Initial
Cardiopulmonary			
Pulse			
Heart			
Lungs			
Abdominal			
E.N.T.			
Skin			
Genitalia			
Tanner Stage		1 2 3 4 5	
Musculoskeletal			
Neck			
Shoulder			
Elbow			
Wrist			
Hand			
Back			
Knee			
Ankle			
Foot			
Other			

Clearance:

A. Cleared

B. Cleared after completing evaluation/rehabilitation for ______________________

C. Not cleared for ☐ Collision ☐ Contact ☐ Noncontact ☐ Strenuous ☐ Moderately Strenuous ☐ Nonstrenuous

Due to ______________________

Physician's Recommendation ______________________

____

____

Name of Physician ______________________ Date ____________

Address ______________________ Telephone ____________

Signature of Physician ______________________ FAX No. ____________

(Over)

PRE-PARTICIPATION PHYSICAL EVALUATION FORM

MEDICAL HISTORY DATA

Please explain "Yes" answers below.

	Question	Yes	No
1.	Have you been hospitalized?	☐	☐
	Have you ever had surgery?	☐	☐
2.	Are you presently taking any medications or pills?	☐	☐
3.	Do you have any allergies (medicine, bees or other stinging insects)?	☐	☐
4.	Have you ever passed out during or after exercise?	☐	☐
	Have you ever been dizzy during or after exercise?	☐	☐
	Have you ever had chest pains during or after exercise?	☐	☐
	Do you tire more quickly than your friends during exercise?	☐	☐
	Have you ever had high blood pressure?	☐	☐
	Have you ever been told that you have a heart murmur?	☐	☐
	Have you ever had racing of your heart or skipped heartbeats?	☐	☐
	Has anyone in your family died of heart problems or a sudden death before age 50?	☐	☐
5.	Do you have any skin problems (itching, rashes, acne)?	☐	☐
6.	Have you ever been knocked out or unconscious?	☐	☐
	Have you ever had a seizure?	☐	☐
	Have you ever had a stinger burner or pinched nerve?	☐	☐
7.	Have you ever had heat or muscle cramps?	☐	☐
	Have you ever been dizzy or passed out in the heat?	☐	☐
8.	Do you have trouble breathing or do you cough during or after activity?	☐	☐
9.	Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)?	☐	☐
10.	Have you ever had any problems with your eyes or vision?	☐	☐
	Do you wear glasses or contacts or protective eye wear?	☐	☐
11.	Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints?	☐	☐

___ Ankle ___ Chest ___ Foot ___ Hand ___ Hip ___ Neck ___ Shoulder ___ Wrist

___ Back ___ Elbow ___ Forearm ___ Head ___ Knee ___ Shin/calf ___ Thigh

	Question	Yes	No
12.	Have you had any other medical problems?	☐	☐

___ Mononucleosis ___ Rheumatic Fever ___ Pertussis ___ Tuberculosis ___ Chicken Pox

___ Other (describe) ____

____

	Question	Yes	No
13.	Have you had a medical problem or injury since your last evaluation?	☐	☐

14. When was your last tetanus shot? Month ________ Date ________ Year ________
15. When was your last measles immunization? Month ________ Date ________ Year ________
16. When was your first menstrual period? ____________________
17. When was your last menstrual period? ____________________
18. When was the longest time between your periods last year? ____________________

Explanation of any "Yes" answers:

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I hereby verify to the best of my knowledge that the answers which have been provided to the above questions are correct.

Signature of Student ______________________________ Date ____________

Signature of Parent/Guardian ______________________________ Date ____________

Note: Please return this form to the Athletic Director after the physician has reviewed and completed the evaluation.