tustin Unified School District
300 South C Street, Tustin, CA 92780
(714) 730-7301 www.tustin.k12.ca.us

Date of Exam _____ Date of Birth _____
Name _____ Sex _____
Age _____ Grade _____ School _____
Sports _____

Preparticipation Physical Evaluation

PART 1 – HEALTH HISTORY – *This section to be completed by student/athlete*

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High Blood Pressure ☐ A heart murmur ☐ High Cholesterol ☐ A heart infection ☐ Kawasaki Disease Other:_____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you know if you have sickle cell disease?		
13. Do you get more tired or short of breath more quickly than you friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
14. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
15. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrthymogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
16. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
17. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
18. Has any family member been diagnosed with sickle cell disease?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
19. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
20. Have you ever had any broken or fractured bones or dislocated joint?		
21. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
22. Have you ever had a stress fracture?		
23. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
24.Do you regularly use a brace, orthotics, or other assistive device?		

MEDICAL QUESTIONS	Yes	No
25. Do you have a bone, muscle, or joint injury that bothers you?		
26. Do any of your joints become painful, swollen, feel warm, or look red?		
27. Do you have any history of juvenile arthritis or connective tissue disease?		
28. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
29. Have you ever used an inhaler or taken asthma medicine?		
30. Is there anyone in your family who has asthma?		
31. Were you born without or are you missing a kidney, any eye, a testicle (males), your spleen, or any other organ?		
32. Do you have groin pain or a painful bulge or hernia in the groin area?		
33. Have you had infectious mononucleosis (mono) within the last month?		
34. Do you have any rashes, pressure sores, or other skin problems?		
35. Have you had a herpes or MRSA skin infection?		
36. Have you ever had a head injury or been diagnosed with a concussion? If yes, please explain on the following page.		
37. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
38. Do you have a history of seizure disorder?		
39. Do you have headaches with exercise?		
40. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
41. Have you ever been unable to move your arms or legs after being hit or falling?		
42. Have you ever become ill while exercising in the heat?		
43. Do you get frequent muscle cramps while exercising?		
44. Do you or someone in your family have sickle cell trait or disease?		
45. Have you had any problems with your eyes or vision?		
46. Have you had any eye injuries?		
47. Do you wear glasses or contact lenses?		
48. Do you wear protective eyewear, such as goggles or a face shield?		
49. Do you worry about your weight?		
50. Are you trying to or has anyone recommended that you gain or lose weight?		
51. Are you on a special diet or do you avoid certain types of foods?		
52. Have you ever had an eating disorder?		
53. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
54. Have you ever had a menstrual period?		
55. How old were you when you had your first menstrual period?		
56. How many periods have you had in the last 12 months?		

Explain all "YES" answers. Describe any other facts that should be disclosed prior to the examination:

_____

_____

_____

_____

_____

Medicines and Allergies: Please list all the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking:

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

I hereby state that, to the best of knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____

Signature of parent/guardian _____

Date _____

PART 2 – EXAMINATION - *This section to be completed by physician or qualified medical examiner*		
Name	Date	
Height	Weight	☐ Male ☐ Female
BP / (/) Pulse	Vision R 20/ L 20/	Corrected ☐ Y ☐ N

	NORMAL	ABNORMAL FINDINGS
MEDICAL		
Appearance • Marfan stigmata (kyphoscoliosis, high arched palate, pectus excavatum, arachnodactyly, arm span>height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/Ears/Nose/Throat • Pupils equal • Hearing		
Hearing		
Lymph Nodes		
(a) Heart • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
(b) Genitourinary (males only)		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
(c) Neurologic		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/Ankle		
Foot/Toes		
Functional • Duck Walk, single leg hop		

(a) Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
(b) Consider GU exam if in private setting. Having third party present is recommended.
(c) Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?

2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

Date of Exam:

Physician Stamp

PART 3 – CLEARANCE FORM - *This section to be completed by physician or qualified medical examiner*

Name _____ Sex ☐ M ☐ F Age _____ Date of Birth _____

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for:

_____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports

  Reason _____

Recommendations _____

_____

_____

_____

_____

EMERGENCY INFORMATION

Allergies _____

_____

_____

_____

_____

Other information _____

_____

_____

_____

_____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician or qualified medical examiner may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician or qualified medical examiner _____ Date _____

Address _____ Phone _____

Signature of physician or qualified medical examiner _____

Completed Cardiac Assessment Professional Development Module

Date _____ Signature _____

School Physician:

Reviewed on _____ Approved _____ Not Approved _____ Signature _____
(Date)