



Pre-participation Physical Evaluation (Page 1 of 2)

Part 1. Student Information (The parent or guardian should fill out this form with assistance from the student.)

| | | | | |
|--------------------------------|-----------|-------------|---------------------|-------------------|
| Name _____ | Sex _____ | Age _____ | Date of Birth _____ | Grade _____ |
| Address _____ | | | Phone _____ | |
| In case of emergency, contact: | | Name: _____ | | |
| Phone (H): _____ | | (W) _____ | | Cell Phone: _____ |

Part 2. Medical History (The parent or guardian should fill out this form with assistance from the student). Explain "yes" answers below. Circle questions you don't know answers to.

| | Yes | No | | Yes | No |
|--|-----------------------|-----------------------|--|-------------------------------|---------------------------------|
| 1. Have you had a medical illness or injury since your last check-up or sports physical? Do you have an ongoing or chronic illness? Are you currently being treated for an injury or condition? _____ | <input type="radio"/> | <input type="radio"/> | 9. Do you cough, wheeze, or have trouble breathing during or after activity? Do you have asthma? Do you use an inhaler? Do you have seasonal allergies that require medical treatment? _____ | <input type="radio"/> | <input type="radio"/> |
| 2. Have you ever been hospitalized overnight? Have you ever had surgery? _____ | <input type="radio"/> | <input type="radio"/> | 10. 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)? _____ | <input type="radio"/> | <input type="radio"/> |
| 3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills? _____ | <input type="radio"/> | <input type="radio"/> | 11. Have you had any problems with your eyes or vision? Do you wear glasses, contacts, or protective eyewear? _____ | <input type="radio"/> | <input type="radio"/> |
| Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? _____ | <input type="radio"/> | <input type="radio"/> | 12. 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? _____ | <input type="radio"/> | <input type="radio"/> |
| 4. Do you have any allergies to medications? _____ Do you have any allergies to pollen, food or stinging insects? _____ | <input type="radio"/> | <input type="radio"/> | If yes, check appropriate box below. | | |
| Have you ever had a rash or hives develop during or after exercise? _____ | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> Head | <input type="radio"/> Elbow | <input type="radio"/> Hip |
| 5. 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 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? Have you had a severe viral infection (i.e., mononucleosis or myocarditis) within the last month? Has a doctor ever denied or restricted your participation in sports for any heart problems? Has anyone in your immediate family had the following conditions? Diabetes _____ Heart disease _____ other _____ Sudden death prior to age 50 _____ High Blood Pressure _____ | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> Neck | <input type="radio"/> Forearm | <input type="radio"/> Thigh |
| 6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> Back | <input type="radio"/> Wrist | <input type="radio"/> Knee |
| 7. 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? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> Chest | <input type="radio"/> Hand | <input type="radio"/> Shin/calf |
| 8. Have you ever become ill from exercising in the heat? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> Shoulder | <input type="radio"/> Finger | <input type="radio"/> Ankle |
| | | | <input type="radio"/> Upper arm | | <input type="radio"/> Foot |
| | | | 13. Do you want to weigh more or less than you do now? | <input type="radio"/> | <input type="radio"/> |
| | | | 14. Do you lose weight regularly to meet requirements for your sport? | <input type="radio"/> | <input type="radio"/> |
| | | | 15. Do you feel stressed? | <input type="radio"/> | <input type="radio"/> |
| | | | 16. Do you or have you ever used: Smokeless tobacco _____ Cigarettes _____ Alcohol _____ Illegal drugs _____ | <input type="radio"/> | <input type="radio"/> |
| | | | 17. Have you ever tested positive for COVID-19 | <input type="radio"/> | <input type="radio"/> |

Explanation: _____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. I understand and acknowledge that truthful and accurate information is essential in properly determining whether the student should be cleared for physical education and/or athletic participation.
 I hereby consent for the student named above, to be given medical care by the doctor selected by the school.

Signature of Parent/Guardian _____ Signature of Student _____ Date _____



Pre-participation Physical Evaluation (Page 2 of 2)

Part 3. Physical Examination (to be completed by physician)

Name: _____ Date of Birth: _____

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

Vision: R 20/ _____ L 20/ _____ Glasses/Contacts: Yes No Pupils: Equal _____ Unequal _____

| Findings | Normal | Abnormal Findings | Initials* |
|------------------------|--------|-------------------|-----------|
| Medical | | | |
| Appearance | | | |
| Skin | | | |
| Eyes/Ears/Nose | | | |
| Throat/ Oropharynx | | | |
| Lymph Nodes | | | |
| Heart | | | |
| Pulses | | | |
| Lungs | | | |
| Abdomen | | | |
| Genitalia/ Hernia | | | |
| Musculoskeletal | | | |
| Neck | | | |
| Back | | | |
| Shoulder/arm | | | |
| Elbow/forearm | | | |
| Wrist/hand | | | |
| Hip/thigh | | | |
| Knee | | | |
| Leg/ankle | | | |
| Foot | | | |

*Station-based examination only

Assessment

- Cleared for all physical activity
 - Cleared after completing evaluation/rehabilitation for: _____

 - Not Cleared for: _____ Reason: _____
- Recommendations: _____

Name of physician (print/type) _____ Date _____

Address: _____ Phone: _____

Signature of physician: _____