EPHRATA SCHOOL DISTRICT SPORTS PHYSICAL
PREPARTICPATION HISTORY AND PHYSICAL EXAMINATION

Name:_____ Birth Date: _____ Exam Date: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Sport(s): _____

HISTORY

Yes	No	
☐	☐	1. Have you had any illness/injury recently, or do you have an illness/injury now?
☐	☐	2. Have you had a medical problem, illness or injury since your last exam?
☐	☐	3. Do you have any chronic or recurrent illness?
☐	☐	4. Have you ever had any illness lasting more than a week?
☐	☐	5. Have you ever been hospitalized overnight?
☐	☐	6. Have you had any surgery other than tonsillectomy?
☐	☐	7. Have you ever had any injuries requiring treatment by a physician?
☐	☐	8. Do you have any organs missing other than tonsils (appendix, eye, kidney, testicle, etc.)?
☐	☐	9. Are you presently taking ANY medications (including birth control pill, vitamin, aspirin, etc.)?
☐	☐	10. Do you have ANY allergies (medicines, bees, foods, or other factors)?
☐	☐	11. Have you ever had chest pain, dizziness, fainting, passing out during or after exercise?
☐	☐	12. Do you tire more easily or quickly than your friends during exercise?
☐	☐	13. Have you ever had any problem with your blood pressure or your heart?
☐	☐	14. Have any close relative had heart problems, heart attack or sudden death before they were age 50?
☐	☐	15. Do you have any skin problems (acne, itching, rashes, etc.)?
☐	☐	16. Have you ever had fainting, convulsions, seizures or severe dizziness?
☐	☐	17. Do you have frequent severe headaches?
☐	☐	18. Have you ever had a "stinger" or "burner" or "pinched nerve"?
☐	☐	19. Have you ever been "knocked out" or "passed out"?
☐	☐	20. Have you ever had a neck or head injury?
☐	☐	21. Have you ever had a concussion? If yes, when _____
☐	☐	22. Have you ever had heat exhaustion, heat stroke, heat cramps or similar heat-related problems?
☐	☐	23. Have you had asthma, trouble breathing, or cough during or after exercise?
☐	☐	24. Do you wear eyeglasses, contact lenses or protective eyewear?
☐	☐	25. Have you had any problems with your eyes or vision?
☐	☐	26. Do you wear any dental appliance such as braces, bridge, plate, or retainer?
☐	☐	27. Have you ever had a knee injury?
☐	☐	28. Have you ever had an ankle injury?
☐	☐	29. Have you ever injured any other joint (should, wrist, fingers, etc.)?
☐	☐	30. Have you ever had a broken bone (fracture)?
☐	☐	31. Have you ever had a cast, splint, or had to use crutches?
☐	☐	32. Must you use special equipment for competition (pads, braces, neck roll, etc.)?
☐	☐	33. Has it been more than 5 years since your last tetanus booster shot?
☐	☐	34. Are you worried about your weight?
☐	☐	35. Have you any medical concerns about participating in your sport?
		FEMALES:
☐	☐	36. Are your periods regular (monthly)?
☐	☐	37. Do you have any menstrual problems or concerns?

**********ATHLETE SHOULD NOT WRITE BELOW THIS LINE**********

EXAMINER'S COMMENTS ON ALL "YES" ANSWERS (refer to question number):

_____

_____

_____

_____

PHYSICAL EXAMINATON

Optional

Name: _____ Age: _____

Height: _____ Blood Pressure: _____

Weight: _____ Visual Acuity: Left 20/_____

Right 20/_____

Pulse: _____

Urinalyis:

Body Fat %:

HCT:

EST VO2 Max:

Audiometry:

Normal		Abnormal	
☐	1. Head	☐	_____
☐	2. Eyes (pupils), ENT	☐	_____
☐	3. Teeth	☐	_____
☐	4. Chest	☐	_____
☐	5. Lungs	☐	_____
☐	6. Heart	☐	_____
☐	7. Abdomen	☐	_____
☐	8. Genitalia	☐	_____
☐	9. Neurologic	☐	_____
☐	10. Skin	☐	_____
☐	11. Physical Maturity	☐	_____
☐	12. Spine, Back	☐	_____
☐	13. Shoulders	☐	_____
☐	14. Upper extremities	☐	_____
☐	15. Lower extremities	☐	_____

Assessment: ☐ Full participation

☐ Limited participation (describe limitations, restrictions):

_____

_____

☐ Participation Contraindicated (list reasons):

_____

_____

Recommendations (equipment, taping, rehabilitation, etc.):

_____

_____

List medication and/or emergency medication needed (i.e. Inhaler, epi-pen) – Must also Complete **"Authorization for Medication at School"** to have on file at school office: _____

_____

The information on this page must be filled in and signed by either a Medical Doctor (MD), Doctor of Osteopathy (DO), Physician Assistant (PA), Advanced Registered Nurse Practitioner (ARNP) or Naturopathic Physician (ND). Exam forms signed by any other health care practitioner will not be accepted.

DATE: _____ LHP SIGNATURE: _____

EXAMINER'S PHONE: ( )_____ PRINT LHP NAME: _____

Medical designation: (circle one): MD DO PA ARNP ND

I authorize _____ to release this information or send a copy to my child's school upon request.

Parent/Guardian Signature _____ Date _____