

BISHOP O'CONNELL HIGH SCHOOL

PRE-PARTICIPATION PHYSICAL EXAMINATION FORM

Form adapted from VHSL
REVISED MAY 2022

Page 1 of 2

PART I- MEDICAL HISTORY

This form must be complete and signed, prior to the physical examination, for review by examining practitioner. Explain "YES" answers below with number of the question. Circle questions you don't know the answers to.							
GENERAL MEDICAL HISTORY		YES	NO	MEDICAL QUESTIONS CONTINUED		YES	NO
1.	Do you have any concerns that you would like to discuss with your provider?	<input type="checkbox"/>	<input type="checkbox"/>	24.	Have you had mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Has a provider ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	25.	Are you missing a kidney, eye, testicle, spleen or other internal organ?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Do you have any ongoing medical conditions? If so, please identify: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	26.	Do you have groin or testicle pain or a painful bulge or hernia in the groin area?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Are you currently taking any medications or supplements on a daily basis?	<input type="checkbox"/>	<input type="checkbox"/>	27.	Have you ever become ill while exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Do you have allergies to any medications?	<input type="checkbox"/>	<input type="checkbox"/>	28.	When exercising in the heat, do you have severe muscle cramps?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?	<input type="checkbox"/>	<input type="checkbox"/>	29.	Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Have you ever spent the night in the hospital? If yes, why? _____	<input type="checkbox"/>	<input type="checkbox"/>	30.	Have you ever had numbness, tingling or weakness in your arms or legs or been unable to move your arms or legs <u>AFTER being hit or falling</u> ?	<input type="checkbox"/>	<input type="checkbox"/>
8.	Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	31.	Do you or does someone in your family have sickle cell trait or disease?	<input type="checkbox"/>	<input type="checkbox"/>
HEART HEALTH QUESTIONS ABOUT YOU		YES	NO	32.	Have you had any other blood disorders?	<input type="checkbox"/>	<input type="checkbox"/>
9.	Have you ever passed out or nearly passed out DURING or AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	33.	Have you had a concussion or head injury that caused confusion, a prolonged headache or memory problems?	<input type="checkbox"/>	<input type="checkbox"/>
10.	Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	34.	Have you had or do you have any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
11.	Does your heart race, flutter in your chest or skip beats (irregular beats) during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	35.	Do you wear glasses or contacts?	<input type="checkbox"/>	<input type="checkbox"/>
12.	Has a doctor ever ordered a test for your heart? For example, electrocardiography or echocardiography.	<input type="checkbox"/>	<input type="checkbox"/>	36.	Do you wear protective eyewear like goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
13.	Has a doctor ever told you that you have any heart problems, including: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki Disease <input type="checkbox"/> Other _____	<input type="checkbox"/>	<input type="checkbox"/>	37.	Do you worry about your weight?	<input type="checkbox"/>	<input type="checkbox"/>
14.	Do you get light-headed or feel shorter of breath than your friends during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	38.	Are you trying to or has anyone recommended that you gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
15.	Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	39.	Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		YES	NO	40.	Have you ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
16.	Does anyone in your family have a heart problem?	<input type="checkbox"/>	<input type="checkbox"/>	41.	Are you on a special diet or do you avoid certain types of foods or food groups?	<input type="checkbox"/>	<input type="checkbox"/>
17.	Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 (including drowning or unexplained car crash)?	<input type="checkbox"/>	<input type="checkbox"/>	42.	Allergies to food or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>
18.	Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?	<input type="checkbox"/>	<input type="checkbox"/>	43.	Have you ever had a COVID-19 diagnosis? Date: _____	<input type="checkbox"/>	<input type="checkbox"/>
19.	Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?	<input type="checkbox"/>	<input type="checkbox"/>	44.	What is the date of your last Tdap or Td (tetanus) immunization? (circle type) Date: _____		
FEMALES ONLY						YES	NO
45.	Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
46.	Age when you had your first menstrual period: _____						
47.	Number of periods in the last 12 months: _____						
48.	When was your most recent menstrual period? _____						
EXPLAIN "YES" ANSWERS BELOW							
		#	>>				
		#	>>				
		#	>>				
		#	>>				
		#	>>				
		#	>>				
BONE AND JOINT QUESTIONS		YES	NO				
20.	Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?	<input type="checkbox"/>	<input type="checkbox"/>	#	>>		
21.	Do you currently have a bone, muscle or joint injury that bothers you?	<input type="checkbox"/>	<input type="checkbox"/>	#	>>		
MEDICAL QUESTIONS		YES	NO	List medications and nutritional supplements you are currently taking here:			
22.	Do you cough, wheeze or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>				
23.	Do you have asthma or use asthma medicine (inhaler, nebulizer)?	<input type="checkbox"/>	<input type="checkbox"/>				

→ Parent/Guardian Signature: _____ Date: _____ → Athlete's Signature: _____

PART II- PHYSICAL EXAMINATION

Form adapted from VHSL
REVISED MAY 2022

The physical examination form is required each school year dated after JUNE 1 of the preceding school year and is good through
MAY 31 of the current school year.

NAME _____ DATE OF BIRTH _____ SCHOOL _____

Height	Weight	<input type="checkbox"/> Male	<input type="checkbox"/> Female
BP /	Resting pulse	Vision R 20/	L 20/
		Corrected	<input type="checkbox"/> Yes <input type="checkbox"/> No

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance (Marfan stigmata: kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse, and aortic insufficiency)		
Eyes/ears/nose/throat (Pupils equal, hearing)		
Lymph nodes		
Heart (Murmurs: auscultation standing, supine, +/- Valsalva)		
Pulses		
Lungs		
Abdomen		
Skin (Herpes simplex virus, lesions suggestive of MRSA or tinea corporis)		
Neurological		

MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional (i.e. Double leg squat, single leg squat, box drop or step drop test)		

Emergency medications required on-site: Inhaler Epinephrine Glucagon Other: _____
COMMENTS:

TB Screening: No risk for TB infection identified No symptoms compatible with active TB disease Risk for TB infection or symptoms identified
Test for TB Infection: TST IGRA Date: _____ TST Reading _____ mm TST/IGRA Result: Positive negative
CXR required if positive test for TB infection or TB symptoms. CXR Date: _____ Normal Abnormal

I have reviewed the data above, reviewed his/her medical history form and make the following recommendations for his/her participation in athletics:

- MEDICALLY ELIGIBLE FOR ALL SPORTS WITHOUT RESTRICTION**
- MEDICALLY ELIGIBLE FOR ALL SPORTS WITHOUT RESTRICTION WITH RECOMMENDATION FOR FURTHER EVALUATION OR TREATMENT OF:** _____
- MEDICALLY ELIGIBLE ONLY FOR THE FOLLOWING SPORTS:** _____
Reason: _____
- NOT MEDICALLY ELIGIBLE PENDING FURTHER EVALUATION OF:** _____
- NOT MEDICALLY ELIGIBLE FOR ANY SPORTS**

By this signature, I attest that I have examined the above student and completed this pre-participation physical including a review of Part II- Medical History.

→ PRACTITIONER SIGNATURE: _____ (MD, DO, NP or PA) + DATE**: _____

EXAMINER'S NAME AND DEGREE (PRINT): _____

OFFICE PHONE NUMBER: _____



+Only signature of Doctor of Medicine, Doctor of Osteopathic Medicine, Nurse Practitioner or Physician's Assistant licensed to practice in the United States will be accepted.