The Medical Eligibility Form is the only form that should be submitted to a school or sports organization.

### ■ PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM	æ	
Name: Date of birth:		_
□ Medically eligible for all sports without restriction		
□ Medically eligible for all sports without restriction with recommendations for further evaluation or treatm	ent of	
□ Medically eligible for certain sports		
□ Not medically eligible pending further evaluation		
□ Not medically eligible for any sports		
Recommendations:		-
I have examined the student named on this form and completed the preparticipation physical eapparent clinical contraindications to practice and can participate in the sport(s) as outlined on examination findings are on record in my office and can be made available to the school at the arise after the athlete has been cleared for participation, the physician may rescind the medical and the potential consequences are completely explained to the athlete (and parents or guardic	this form. A copy of request of the parent: eligibility until the pro	the p hysical s. If c onditions
Name of health care professional (print or type):	Date:	
Address:		
Signature of health care professional:		
SHARED EMERGENCY INFORMATION		
Allergies:		_
Medications:	The state of the s	_
		•
Other information:	6	•
		-
Emergency contacts:		_

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## PREPARTICIPATION PHYSICAL EVALUATION

# **HISTORY FORM**

Note: Complete and sign this form (with your parents if	younger than 18) before your appointment.		
Name:	Date of birth:		
Date of examination:	Sport(s):		
Sex assigned at birth (F, M, or intersex):	How do you identify your gender? (F, M, or other):		
List past and current medical conditions.			
Have you ever had surgery? If yes, list all past surgical p	procedures.		
Medicines and supplements: List all current prescription	ns, over-the-counter medicines, and supplements (herbal and nutritional).		
Do you have any allergies? If yes, please list all your a	allergies (ie, medicines, pollens, food, stinging insects).		

Patient Health Questionnaire Version 4 (PHQ-4)				
Over the last 2 weeks, how often have you been bothere	d by any of t	he following proble	ems? (Circle response.)	
	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	Ų.	2	3
Feeling down, depressed, or hopeless	0	I	2	3
(A sum of >3 is considered positive on either subs	cale [question	ns I and 2, or ques	tions 3 and 4] for scree	ening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
I. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
<ol><li>Do you have any ongoing medical issues or recent illness?</li></ol>		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
Does your heart ever race, flutter in your chest,     or skip beats (irregular beats) during exercise?	20.	
7. Has a doctor ever told you that you have any heart problems?		
<ol> <li>Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.</li> </ol>		

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
12. 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)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?	2013	

ONE AND JOINT QUESTIONS	Yes	No	MEDICAL QUESTIONS (CONTINUED )	Yes	I
lave you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that			<ul><li>25. Do you worry about your weight?</li><li>26. Are you trying to or has anyone recommended</li></ul>		
caused you to miss a practice or game?			that you gain or lose weight?		L
you have a bone, muscle, ligament, or joint ury that bothers you?			27. Are you on a special diet or do you avoid certain types of foods or food groups?		
CAL QUESTIONS	Yes	No	28. Have you ever had an eating disorder?		
you cough, wheeze, or have difficulty reathing during or after exercise?			FEMALES ONLY	Yes	N
ou missing a kidney, an eye, a testicle es), your spleen, or any other organ?			29. Have you ever had a menstrual period?  30. How old were you when you had your first menstrual period?		
you have groin or testicle pain or a painful ge or hernia in the groin area?			31. When was your most recent menstrual period?		
you have any recurring skin rashes or shes that come and go, including herpes or thicillin-resistant Staphylococcus aureus RSA)?			32. How many periods have you had in the past 12 months?  Explain "Yes" answers here.		
rou had a concussion or head injury that I confusion, a prolonged headache, or rry problems?					
e you ever had numbness, had tingling, had akkness in your arms or legs, or been unable move your arms or legs after being hit or ing?					
ve you ever become ill while exercising in the eat?					
o you or does someone in your family have ickle cell trait or disease?					
				·	

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Signature of parent or guardian:

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### PREPARTICIPATION PHYSICAL EVALUATION

### PHYSICAL EXAMINATION FORM

Name:	Date of birth:

#### 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, e-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-enhancing 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?

EXAMINATION					
Height: Weight:			MARIO DI COMPANIO DE LA COMPANIO DE		Vanile and depth of Artist 20, 1915 (1919 and Artist 1916)
BP: / ( / ) Pulse:	Vision: R 20/	L 20	/ Corre	cted: 🗆 Y 🖸	1 N
MEDICAL				NORMAL	ABNORMAL FINDINGS
Appearance  Marfan stigmata (kyphoscoliosis, high-	The second secon	arachno dactyly,	hyperlaxity,		
myopia, mitral valve prolapse [MVP], Eyes, ears, nose, and throat Pupils equal Hearing	and aortic insufficiency)				
Lymph nodes					
Heart <sup>a</sup> • Murmurs (auscultation standing, auscu	ıltation supine, and ± Valsalva mar	neuver)			
Lungs					
Abdomen					
Skin  Herpes simplex virus (HSV), lesions sug tinea corporis	gestive of methicillin-resistant <i>Staph</i>	nylococcus aure	eus (MRSA), or		
Neurological					
MUSCULOSKELETAL				NORMAL	ABNORMAL FINDINGS
Neck					
Back					
Shoulder and arm					
Elbow and forearm					
Wrist, hand, and fingers					
Hip and thigh					
Knee					
Leg and ankle					
Foot and toes					
Functional  Double-leg squat test, single-leg squat	test, and box drop or step drop te	st			
<sup>a</sup> Consider electrocardiography (ECG), ech nation of those.	ocardiography, referral to a cardio	logist for abnorn	mal cardiac histo	ry or examina	ation findings, or a combi-
Name of health care professional (print or	type):			Date:	
A 11					
Signature of health care professional:			-		, MD, DO, NP, or P

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