

**PASCO SCHOOL DISTRICT
PRE-PARTICIPATION HISTORY AND PHYSICAL EXAMINATION**

**I UNDERSTAND THAT TOTAL FREEDOM FROM HEALTH PROBLEMS CANNOT BE GUARANTEED BY THE
PHYSICIAN PERFORMING THIS PHYSICAL EXAM/SCREENING.**

EXAM DATE: _____ PARENT/GUARDIAN SIGNATURE: **X** _____

NAME: _____ BIRTHDATE: _____ SCHOOL: _____

ADDRESS: _____ CITY: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____ SPORT: _____

HISTORY

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

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

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

PHYSICAL EXAMINATION/SCREENING

NAME: _____ **GRADE:** _____ **SCHOOL:** _____

Age: _____ Pulse: _____
Height: _____ Blood Pressure: _____
Weight: _____ Visual Acuity: Left 20/ _____
Right 20/ _____

(Optional)

Urinalysis:
Body Fat %
HCT:
EST VO2 Max:
Audiometry:

Normal

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

Abnormal

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Assessment: Full participation
 Limited participation (describe limitations, restrictions):

Participation contraindicated (list reasons):

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

EXAMINER'S SIGNATURE: _____ **TODAY'S DATE:** _____

EXAMINER'S PHONE: _____ **PRINT/STAMP EXAMINER'S NAME:** _____