

# PRE-PARTICIPATION PHYSICAL EVALUATION

*To be completed by the Physician/Licensed Examiner for School:*

STUDENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_

<b>EXAMINATION</b>			
Height: _____	Weight: _____	Pulse: _____	Blood Pressure: _____ / _____
Vision R 20/ _____	L 20/ _____	Corrected: Yes _____ No _____	Pupils: Equal _____ Unequal _____
Hearing: Normal _____	Referred _____	Spinal Exam: Normal _____ Referred _____	% Body Fat (optional) _____

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
Eyes/ears/nose/throat		
Lymph nodes		
Heart-Auscultation of the heart in the <b>supine</b> position		
Heart-Auscultation of the heart in the <b>standing</b> position		
Heart-lower extremity pulses		
Pulses		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		

MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		

*The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination forms signed by any other health care practitioner, will not be accepted.*

<b>CLEARANCE</b>	
<input type="checkbox"/> Cleared for all sports without restriction  <input type="checkbox"/> Cleared for all sports without restriction with recommendations for further evaluation or treatment for: _____  <input type="checkbox"/> Not cleared	<input type="checkbox"/> Pending further evaluation <input type="checkbox"/> For any sport <input type="checkbox"/> For certain sports: Reason: _____ Recommendations: _____
Physician/Clinician Signature: _____	
Physician/Clinician Print Name: _____	
Address: _____	
Phone: _____	Date of Exam: _____

# PRE-PARTICIPATION PHYSICAL EVALUATION

*To be completed by the Parent for Healthcare Provider:*

**DIRECTIONS:** Complete questions below and explain “YES” answers in the space provided.

GENERAL QUESTIONS	YES	NO	UNSURE
1. Has your doctor ever denied or restricted your participation in sports for any reason?			
2. Do you have any ongoing medical conditions? If so check all that apply: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections <input type="checkbox"/> Other: _____			
3. Have you ever spent the night in the hospital in the past year?			
4. Have you ever had surgery?			
HEART HEALTH QUESTIONS	YES	NO	UNSURE
5. Have you ever passed out or nearly passed out during or after exercise?			
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			
7. Does your heart ever race or skip beats (irregular beats) during exercise?			
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> High cholesterol <input type="checkbox"/> Kawasaki disease <input type="checkbox"/> A heart murmur <input type="checkbox"/> A heart infection <input type="checkbox"/> Other: _____			
9. Do you get lightheaded or feel more short of breath than expected during exercise?			
10. Have you ever had an unexplained seizure?			
11. Do you get more tired or short of breath more quickly than your friends during exercise?			
FAMILY HEART HEALTH QUESTIONS	YES	NO	UNSURE
12. Has any family member or relative died of heart problems or unexpected sudden death before age 50?			
13. Has any family member been diagnosed with a heart condition?			
BONE AND JOINT QUESTIONS	YES	NO	UNSURE
14. Have you had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or game?			
15. Have you had any fractured bones or dislocated joints?			
16. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast?			
17. Do you regularly use a brace, orthotics or other assistive device?			
18. Do any of your joints become painful, swollen, feel warm or look red?			
MEDICAL QUESTIONS	YES	NO	UNSURE
19. Do you cough, wheeze, or have difficulty breathing during or after exercise?			
20. Do you have any allergies? If so, check all that apply: <input type="checkbox"/> Pollen <input type="checkbox"/> Medicine <input type="checkbox"/> Food <input type="checkbox"/> Stinging Insects <input type="checkbox"/> Other: _____			
21. Are you missing any paired organs?			
22. Have you had a severe viral infection (myocarditis, mononucleosis, etc.) in the past year?			
23. Do you currently have any skin problems (itching, acne, warts, fungus, or blisters)?			
24. Have you ever had a head injury or concussion?			
25. Have you ever been knocked unconscious or lost memory?			
26. Do you have a history of seizure disorder?			
27. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?			
28. Have you ever become ill while exercising in the heat?			
29. Have you been diagnosed with or treated for Sickle Cell Trait or Sickle Cell Disease?			
30. Have you had any problems with your eyes or vision?			
31. Have you ever had unexpected shortness of breath with exercise?			
32. Have you had any eye injuries?			
33. Do you use any special protective or corrective equipment?			
34. Do you lose weight regularly to meet weight requirements for an extra-curricular activity?			
35. Are you on a special diet or do you avoid certain foods?			
36. Have you ever had an eating disorder?			
37. Are you presently under a doctor's care?			
38. Do you have any concerns you would like to discuss with a doctor?			
FEMALES ONLY			
39. What year was your first menstrual cycle?			
40. What month and day was your most recent menstrual cycle?			
41. How many cycles have you had in the last 12 months?			
COVID-19 MEDICAL QUESTIONS			
42. Have you been diagnosed with COVID-19 at any time?			
43. Have you been hospitalized at any time due to COVID-19?			