Grand Island Central School District
Preparticipation Physical Evaluation

Name (Last, First) ____ **Gender** ______ **DOB** _________________________

Name of Primary Physician __________________________________ **MD Phone Number:** _________________________

*I consent as the parent/guardian to allow above physician(s) or health care provider(s) to share appropriate information concerning my child that is relevant to participation in athletics and activities with the athletic department, school health department and other school personnel. I also consent that district provided health care provider(s) may perform a pre-participation health exam on my child.

Parent Signature: ____ **Date:** ________________________

Medical History

	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2. Do you have an ongoing medical condition (i.e. diabetes or asthma)?	☐	☐
3. Are you taking any prescription or non-prescription (over the counter) medicines or pills?	☐	☐
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐
5. Have you ever passed out or nearly passed out DURING exercise?	☐	☐
6. Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
7. Have you ever had discomfort, pain, or pressure, in your chest during exercise?	☐	☐
8. Does your heart race or skip beats during exercise?	☐	☐
9. Has your doctor ever told you that you have high blood pressure, high cholesterol, a heart murmur, a heart infection?	☐	☐
10. Has a doctor ever ordered a test for your heart (i.e. ECG, echocardiogram)?	☐	☐
11. Has anyone in your family ever died for no apparent reason?	☐	☐
12. Does anyone in your family have a heart problem?	☐	☐
13. Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
14. Does anyone on your family have Marfan syndrome?	☐	☐
15. Have you ever spent the night in a hospital?	☐	☐
16. Have you ever had surgery?	☐	☐
17. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
18. Do you regularly use a brace or assistive device?	☐	☐
19. Has a doctor ever told you that you have asthma or allergies?	☐	☐
20. Do you cough wheeze, or have difficulty breathing during or after exercise?	☐	☐
21. Is there anyone in your family that has asthma?	☐	☐
22. Have you ever used an inhaler or taken asthma medicine?	☐	☐
23. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
24. Have you had infectious mononucleosis (mono) within the last month?	☐	☐
25. Do you have rashes, pressure sores, or other skin problems?	☐	☐
26. Have you had a herpes skin infection?	☐	☐
27. Have you ever had a head injury or concussion? If yes, how many? _______ Most recent? ____________	☐	☐
28. Have you been hit in the head and been confused or lost your memory?	☐	☐
29. Have you ever had a seizure?	☐	☐
30. Do you have headaches with exercise?	☐	☐
31. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
32. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
33. When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
34. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
35. Have you had any problems with your eyes or vision?	☐	☐
36. Do you wear protective eyewear such as goggles or a face shield?	☐	☐
37. Are you happy with your weight?	☐	☐
38. Are you trying to gain or lose weight?	☐	☐
39. Has anyone recommended you change your weight or eating habits?	☐	☐
40. Do you limit or carefully control what you eat?	☐	☐
41. Do you have any concerns that you would like to discuss with a doctor?	☐	☐
42. Have you ever had an injury like a sprain, muscle or ligament tear that caused you to miss a practice or game?	☐	☐
43. Have you have had any broken or fractured bones or dislocated joints?	☐	☐
44. Have had a bone or joint injury that required x-ray, MRI, CT, surgery, injection, or physical therapy?	☐	☐

Explain all YES answers here: ____

____

____

Females Only

	Yes	No
42. Have you ever had a menstrual period?	☐	☐
43. How old were you when you had your first menstrual period? ______		
44. How many periods have you had in the last 12 months? ______		

Revised 7/2021