ALABAMA HIGH SCHOOL ATHLETIC ASSOCIATION

Preparticipation Physical Evaluation Form Revised 2018

Revised 2018

Name	History		Date		
Explain "Yes" answers below: 1. Has a doctor ever restricted/denied your participation in sports? 2. Have you ever been hospitalized or spent a night in a hospital? 3. Do you have any ongoing medical conditions (like Diabetes or Asthma)? 4. Are you presently taking any medications or pilk (prescription or over-the-counter? 5. Do you have any vallengles (medicine, polies, foods, bees or other stinging insects)? 6. Have you ever based out during or after exercise? 6. Have you ever bane dizzy during or after exercise? 6. Have you ever had chest pain or disconflort in your chest during or after exercise? 6. Have you ever had chest pain or disconflort in your chest during or after exercise? 6. Have you ever had chest pain or disconflort in your chest during or after exercise? 6. Have you ever had placed to the state of the state	Name	Sex Age	Date of birt	:h	
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8. Have you ever had a head injury or concussion? Have you ever been knocked out or unconscious? Have you ever had a stinger, burner, pinched nerve, or loss of feeling or weakness in your arms or legs? 9. Have you ever had heat or muscle cramps? Have you ever had heat or muscle cramps? Have you ever been dizzy or passed out in the heat? 10. Do you have trouble breathing or do you cough during or after activity? Do you take any medications for asthma (for instance, inhalers)? 11. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)? 12. Have you had any problems with your eyes or vision? Do you wear glasses or contacts or protective eye wear? 13. Have you had any other medical problems (infectious mononucleosis, diabetes, infectious diseases, etc.)? 14. Have you had any other medical problems (infectious mononucleosis, diabetes, infectious diseases, etc.)? Have you ever been told you have sickle cell trait? Has anyone in your family had sickle cell disease or sickle cell trait? Has anyone in your family had sickle cell disease or sickle cell trait? Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints? Head Back Shoulder Forearm Hand Hip Knee Ankle Neck Chest Elbow Wrist Finger Thigh Shin Foot 17. When was your first menstrual period? When was your list menstrual period? When was your first menstrual p		Has a doctor ever ordered a test on your heart (EKG, echocardiogram)?			
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Signature of athlete Date	I hereby :	state that, to the best of my knowledge, my answers to the above questions are correct.			
Signature of parent/guardian DUPLICATE AS NEEDEL					
	Signature	of parent/guardian	DUI	PLICATE AS	NEEDE

FORM 5

Preparticipation Physical Evaluation Rule 1, Sec. 14 — In order for a student to be eligible for interscholastic athletics, there must be on file in the Superintendent's or Principal's office a current physician's statement certifying that the student has passed a physical exam, and that in the opinion of the examining physician (M.D. or D.O.) the student is fully able to participate in interscholastic athletics (Grades 7-12). The Student's name AHSAA Physicians Certificate (Form 5 Rev. 2018) must be used. A physical exam will satisfy the requirement for one calendar year through the end of the month from the date of the exam. For Physical Examination example, a physical given on May 5, 2021, will satisfy the requirement through May 31, 2022. Height _____ Weight ____ BP ___ / ___ Pulse ____ Revised 2018 Vision R 20 / ___ L 20 / ___ Corrected: Y N Abnormal Findings Normal LIMITED Cardiovascular Pulses Heart Lungs Skin E.N.T. Abdominal COMPLETE Genitalia (males) Musculoskeletal Neck Shoulder Elbow Wrist Hand Back Knee Ankle Foot Other Clearance: A. Cleared B. Cleared after completing evaluation/rehabilitation for: ☐ Collision C. Not cleared for: ☐ Contact ☐ Noncontact ____ Strenuous ____ Moderately strenuous ____ Nonstrenuous Due to: Recommendation: Name of physician ______ Date ______

(Form must be signed and dated by the attending physician.)

Address

Signature of physician ____

_____, M.D. or D.O.