

Bellflower Unified School District Pre-Participation Physical Evaluation

Name _____ Sex _____ Age _____ Date of birth _____
 Grade _____ School _____ Sport(s) _____

History - Explain "Yes" answers below. Circle questions you don't know the answers to.

1. Has a doctor ever denied or restricted your participation in sports for any reason? Yes No 2. Do you have an ongoing medical condition (like diabetes or asthma)? Yes No 3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills? Yes No 4. Do you have any allergies to medicines, pollens, foods, or stinging insects? Yes No 5. Have you ever passed out or nearly passed out DURING exercise? Yes No 6. Have you ever passed out or nearly passed out AFTER exercise? Yes No 7. Have you ever had discomfort, pain, or pressure in your chest during exercise? Yes No 8. Does your heart race or skip beats during exercise? Yes No 9. Has a doctor ever told you that you have (check all that apply): High blood pressure Heart murmur High cholesterol Heart infection Yes No 10. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram) Yes No 11. Has anyone in your family died for no apparent reason? Yes No 12. Does anyone in your family have a heart problem? Yes No 13. Has any family member or relative died of heart problems or of sudden death before age 50? Yes No 14. Does anyone in your family have Marfan syndrome? Yes No 15. Have you ever spent the night in a hospital? Yes No 16. Have you ever had surgery? Yes No 17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below: Yes No 18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below: Yes No 19. Have you had a bone or joint injury that required xrays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below: Yes No Head Neck Shoulder Upper Arm Elbow Forearm Hand/Fingers Chest Upper Back Lower Back Hip Thigh Knee Calf/Shin Ankle Foot/Toes 20. Have you ever had a stress fracture? Yes No	21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? Yes No 22. Do you regularly use a brace or assistive device? Yes No 23. Has a doctor ever told you that you have asthma or allergies? Yes No 24. Do you cough, wheeze, or have difficulty breathing during or after exercise? Yes No 25. Is there anyone in your family who as asthma? Yes No 26. Have you ever used an inhaler or taken asthma medicine? Yes No 27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? Yes No 28. Have you had infectious mononucleosis (mono) within the last month? Yes No 29. Do you have any rashes, pressure sores, or other skin problems? Yes No 30. Have you had a herpes skin infection? Yes No 31. Have you ever had a head injury or concussion? Yes No 32. Have you been hit in the head and been confused or lost your memory? Yes No 33. Have you ever had a seizure? Yes No 34. Do you have headaches with exercise? Yes No 35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? Yes No 36. Have you ever been unable to move your arms or legs after being hit or falling? Yes No 37. When exercising in the heat, do you have severe muscle cramps or become ill? Yes No 38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? Yes No 39. Have you had any problems with your eyes or vision? Yes No 40. Do you wear glasses or contact lenses? Yes No 41. Do you wear protective eyewear, such as goggles or a face shield? Yes No 42. Are you happy with your weight? Yes No 43. Are you trying to gain or lose weight? Yes No 44. Has anyone recommended you change your weight or eating habits? Yes No 45. Do you limit or carefully control what you eat? Yes No 46. Do you have any concerns that you would like to discuss with a doctor? Yes No FEMALES ONLY 47. Have you ever had a menstrual period? Yes No 48. How old were you when you had your first menstrual period? 49. How many periods have you had in the last 12 months?
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Explain "Yes" answers here:

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ **Signature of parent/guardian** _____ **Date** _____

Physician's Physical Evaluation

Height _____ Weight _____ % Body fax (optional) _____ Pulse _____ BP ____ / ____ (____ / ____ , ____ / ____)

Vision R 20/ ____ L 20/ ____ Corrected: Y N Pupils: Equal ____ Unequal ____

☐ Cleared ☐ Cleared after completing evaluation/rehabilitation for: _____
☐ Not cleared for: _____ Reason: _____

Name of physician (print/type) _____ Address _____ **Date** _____

Signature of physician _____ MD, DO, NP, DC, or PA License # _____ (Please stamp form upon approval)