

## PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

This **MEDICAL HISTORY FORM** must be completed **annually** by parent (or guardian) and student in order for the student to participate in activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an event.

Student's Name: (print) \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_  
 Grade \_\_\_\_\_ School \_\_\_\_\_  
 Personal Physician \_\_\_\_\_ Phone \_\_\_\_\_  
*In case of emergency, contact:*  
 Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_

Explain "Yes" answers in the box below\*\*. Circle questions you don't know the answers to.

	Yes	No		Yes	No
1. Have you had a medical illness or injury since your last check up or physical?	<input type="checkbox"/>	<input type="checkbox"/>	13. Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you been hospitalized overnight in the past year? Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	14. Do you use any special protective or corrective equipment or devices that aren't usually used for your activity or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had prior testing for the heart ordered by a physician?	<input type="checkbox"/>	<input type="checkbox"/>	15. Have you ever had a sprain, strain, or swelling after injury?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	16. Have you broken or fractured any bones or dislocated any joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	17. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	<input type="checkbox"/>	<input type="checkbox"/>
Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, check appropriate box and explain below:		
Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Head	<input type="checkbox"/> Elbow	<input type="checkbox"/> Hip
Have you had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/> Forearm	<input type="checkbox"/> Thigh
Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Back	<input type="checkbox"/> Wrist	<input type="checkbox"/> Knee
Has any family member or relative died of heart problems or of sudden unexpected death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest	<input type="checkbox"/> Hand	<input type="checkbox"/> Shin/Calf
Has any family member been diagnosed with enlarged heart, (dilated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome or other ion channelopathy (Brugada syndrome, etc.), Marfan's syndrome, or abnormal heart rhythm?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Finger	<input type="checkbox"/> Ankle
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Upper Arm	<input type="checkbox"/> Foot	
Has a physician ever denied or restricted your participation in activities for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	18. Do you want to weigh more or less than you do now?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	19. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been knocked out, become unconscious, or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>	20. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how many times? _____			21. Have you been diagnosed with a seizure disorder?	<input type="checkbox"/>	<input type="checkbox"/>
When was your last concussion? _____			22. Have you been diagnosed as a Type I or Type II diabetic?	<input type="checkbox"/>	<input type="checkbox"/>
How severe was each one? (Explain in below)			<i>Females Only</i>		
Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	23. When was your first menstrual period? _____		
Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	24. When was your most recent menstrual period? _____		
Have you ever had numbness or tingling in your arms, hands, legs or feet?	<input type="checkbox"/>	<input type="checkbox"/>	25. How much time do you usually have from the start of one period to the start of another? _____		
Have you ever had a stinger, burner, or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	26. How many periods have you had in the last year? _____		
5. Are you missing any paired organs?	<input type="checkbox"/>	<input type="checkbox"/>	27. What was the longest time between periods in the last year? _____		
6. Are you under a doctor's care?	<input type="checkbox"/>	<input type="checkbox"/>	<i>Males Only</i>		
7. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	28. Do you have two testicles? _____		
8. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>	29. Do you have any testicular swelling or masses? _____		
9. Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<b>EXPLAIN 'YES' ANSWERS IN THE BOX BELOW</b> (Attach another sheet if necessary)		
10. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>			
11. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>			
12. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>			

It is understood that even though protective equipment is worn by athletes, whenever needed, the possibility of an accident still remains. Houston Christian High School does not assume any responsibility in case an accident occurs.

If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given said student by any physician, athletic trainer, nurse, school representative or official healthcare provider. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student.

If, between this date and the beginning of participation, any illness or injury should occur that may limit this student's participation, I agree to notify the school authorities of such illness or injury.

**I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Failure to provide truthful responses could subject the student in question to penalties determined by Duchesne Academy of the Sacred Heart.**

Student Signature: \_\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Any Yes answer to questions 1, 2, 3, 4, 5, or 6 requires further medical evaluation which may include a physical examination. Written clearance from a physician, physician assistant, or nurse practitioner is required before any participation in Duchesne Academy practices, games or matches. **THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE, PERFORMANCE OR CONTEST BEFORE, DURING OR AFTER SCHOOL.**

*For School Use Only:*

This Medical History Form was reviewed by: Printed Name \_\_\_\_\_ Date \_\_\_\_\_ Signature \_\_\_\_\_

### Preparticipation Physical Evaluation - Physical Examination

Student's Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_ ( \_\_\_\_\_ / \_\_\_\_\_, \_\_\_\_\_ / \_\_\_\_\_)  
 Vision: R: 20/\_\_\_\_ L: 20/\_\_\_\_ Corrected: Y \_\_\_\_\_ N \_\_\_\_\_ Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

As a minimum requirement, this Physical Examination Form must be completed prior to each year of high school before a student participates in any practice (before, during or after school), in season or out of season, games, matches or competitions.

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS*
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart-Auscultation of the heart in the supine position			
Heart-Auscultation of the heart in standing position			
Heart-Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			
<b>MUSCULOSKELETAL</b>			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

\*Station-based examination only

**CLEARANCE**

- Cleared for all sport activity
- Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_

Not cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_

Recommendations: \_\_\_\_\_

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, or a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners. Examination forms signed by any other health care practitioner or parent who is a Healthcare Provider, will not be accepted.

Name \_\_\_\_\_ Date of Examination \_\_\_\_\_  
 Address \_\_\_\_\_  
 Phone Number \_\_\_\_\_ Signature \_\_\_\_\_