De La Salle High School
1130 Winton Drive, Concord, CA 94518
Phone: (925) 288-8100 Fax: (925) 686-3474

Pre-participation Physical Evaluation (Page 1 of 2)

Part 1. Student Information (The parent or guardian should fill out this form with assistance from the student.)

Name _____ **Sex** _____ **Age** _____ **Date of Birth** _____ **Grade** _____

Address _____ **Phone** _____

In case of emergency, contact: **Name:** _____

Phone (H): _____ **(W)** _____ **Cell Phone:** _____

Part 2. Medical History (The parent or guardian should fill out this form with assistance from the student). Explain "yes" answers below. Circle questions you don't know answers to.

	Yes	No
1. Have you had a medical illness or injury since your last check-up or sports physical?	O	O
Do you have an ongoing or chronic illness?	O	O
Are you currently being treated for an injury or condition?	O	O
2. Have you ever been hospitalized overnight?	O	O
Have you ever had surgery?	O	O
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills?	O	O
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	O	O
4. Do you have any allergies to medications?	O	O
Do you have any allergies to pollen, food or stinging insects?	O	O
Have you ever had a rash or hives develop during or after exercise?	O	O
5. Have you ever passed out during or after exercise?	O	O
Have you ever been dizzy during or after exercise?	O	O
Have you ever had chest pain during or after exercise?	O	O
Do you get tired more quickly than your friends during exercise?	O	O
Have you ever had racing of your heart or skipped heartbeats?	O	O
Have you had high blood pressure or high cholesterol?	O	O
Have you ever been told you have a heart murmur?	O	O
Have you had a severe viral infection (i.e., mononucleosis or myocarditis) within the last month?	O	O
Has a doctor ever denied or restricted your participation in sports for any heart problems?	O	O
Has anyone in your immediate family had the following conditions?	O	O
Diabetes _____ Heart disease _____ other _____		
Sudden death prior to age 50 ___ High Blood Pressure _____		
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	O	O
7. Have you ever had a head injury or concussion?	O	O
Have you ever been knocked out, become unconscious, or lost your memory?	O	O
Have you ever had a seizure?	O	O
Do you have frequent or severe headaches?	O	O
Have you ever had numbness or tingling in your arms, hands, legs, or feet?	O	O
Have you ever had a stinger, burner, or pinched nerve?	O	O
8. Have you ever become ill from exercising in the heat?	O	O

	Yes	No
9. Do you cough, wheeze, or have trouble breathing during or after activity?	O	O
Do you have asthma?	O	O
Do you use an inhaler?	O	O
Do you have seasonal allergies that require medical treatment?	O	O
10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? _____	O	O
11. Have you had any problems with your eyes or vision?	O	O
Do you wear glasses, contacts, or protective eyewear?	O	O
12. Have you ever had a sprain, strain, or swelling after injury?	O	O
Have you broken or fractured any bones or dislocated any joints?	O	O
Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	O	O

If yes, check appropriate box below.

O Head	O Elbow	O Hip
O Neck	O Forearm	O Thigh
O Back	O Wrist	O Knee
O Chest	O Hand	O Shin/calf
O Shoulder	O Finger	O Ankle
O Upper arm		O Foot

13. Do you want to weigh more or less than you do now?	O	O
14. Do you lose weight regularly to meet requirements for yoursport?	O	O
15. Do you feel stressed?	O	O
16. Do you or have you ever used:	O	O

Smokeless tobacco _____ Cigarettes _____
Alcohol _____ Illegal drugs _____

Explanation: _____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.
I understand and acknowledge that truthful and accurate information is essential in properly determining whether the student should be cleared for physical education and/or athletic participation.
I hereby consent for the student named above, to be given medical care by the doctor selected by the school.

_____ _____ _____
Signature of Parent/Guardian **Signature of Student** **Date**

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Part 3. Physical Examination (to be completed by an MD or DO)

Name: _____ Date of Birth: _____

Height: _____ Weight: _____ % Body Fat (optional)_____ Pulse: _____ BP: ____/____

Vision: R 20/ _____ L 20/ _____ Glasses/Contacts: Yes No Pupils: Equal _____ Unequal _____

Findings	Normal	Abnormal Findings	Initials*
Medical			
Appearance			
Skin			
Eyes/Ears/Nose			
Throat/ Oropharynx			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia/ Hernia			
Musculoskeletal			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
Foot			

***Station-based examination only**

Assessment

☐ Cleared for all physical activity

☐ Cleared after completing evaluation/rehabilitation for: _____
_____
_____

☐ Not Cleared for: _____ Reason: _____
Recommendations: _____
_____

Name of physician MD or DO _____ Date _____

Address:_____ Phone: _____

Signature of physician: _____

Pre-participation Physical Evaluation Forms *are based on recommendations developed by the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine and American Osteopathic Academy for Sports Medicine.*