

Preparticipation Physical Examination

The section below is to be completed by a physician or staff after history and consent forms are completed.

WEIGHT: _____ HEIGHT _____ PULSE _____ BP _____

VISION: R- 20/ _____ L 20/ _____ CORRECTED: YES or NO PUPILS: EQUAL or UNEQUAL

EMERGENCY INFORMATION:

Allergies:

Other Information:

MEDICAL

Appearance

- Marfan stigmata (kyphoscoliosis, high arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, m myopia, MVP, aortic insufficiency)

Eyes/ Ears/ Nose/ Throat

- Pupils equal
- Hearing

Lymph Nodes

Heart

Murmurs (auscultation standing, supine, +1- Valsalva), Location of point of maximal impulse (PMI)

Lungs

Abdomen

Genitourinary (males only)

Skin

HSV, lesions suggestive of MRSA, tinea corporis

Neurologic

MUSCULOSKELETAL

Neck/ Back

Shoulder/ Arm/ Elbow/ Forearm

Wrist/ Hand/ Fingers

Hip/ Thigh

Knee/ Leg / Ankle

Foot/ Toes

Functional

Duck walk, single leg hop

CLEARANCE

☐ Medically eligible for all sports/activities without restriction

☐ Medically eligible for all sports/activities without restriction with recommendations for further evaluation or treatment of:

☐ Medically eligible for certain sports/activities:

☐ Not medically eligible pending further evaluation:

☐ Not medically eligible for any sports/activities:

Recommendations: _____

I have evaluated the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent contraindications to practice, tryout, and participate in the sport(s) as outlined above.

Name of Physician/ Provider (print and include official stamp) (MD, DO, NP or PA): _____ Date: _____

Address: _____ Phone: _____

Signature of Physician/ Provider: _____

CONSENT TO TREAT

YES

NO

I give consent to the Athletic Trainer, Team Physician, and/or other qualified Healthcare Professionals (employed with FUSD) to provide care as indicated.

CONSENT FOR PARTICIPATION IN SPORTS

YES

NO

I give my consent for my child to participate in school-sponsored athletic programs and activities.

Parent/Guardian _____ Signature _____ Date _____

Preparticipation Physical Evaluation

*PARENT SIGNATURE & consent on page 2

Date of Exam: _____

Student's Name: _____ Sex: _____ Age: _____ Date of Birth: _____ Grade: _____

School: _____ Sport(s): _____

Home Address: _____ Home Phone #: _____

Personal Physician's/Provider's Name: _____ Personal Physician's/Provider's Phone #: _____

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

Emergency Contact's Telephone #s: Home: _____ Work: _____ Cell #1: _____ Cell #2: _____

Medicines and Allergies: Please list all the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking:

Do you have any allergies? ☐ Yes ☐ No. If yes, please identify specific allergy or allergies below:

☐ Medicines: _____ ☐ Pollens: _____ ☐ Food: _____ ☐ Stinging insects: _____

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

MEDICAL HISTORY QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted our participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: O Anemia O Diabetes O Other:		
3. Have you ever spent the night in a hospital?		
4. Have you ever had surgery?		
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, shortness of breath, lightheadedness, pain, tightness, or pressure in our chest during exercise?		
7. Does your heart ever race or skip beats during exercise?		
8. Has a doctor ever told you that you have any heart problems?		
9. Have you ever had an unexplained seizure? Or history of seizure disorder?		
10. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before the age of 35 including drowning or unexplained car crash?		
11. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
12. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator before age 35?		
13. Have you ever had an injury, like a sprain, muscle tear, ligament tear, tendinitis, fractured bone or dislocated joint?		
14. Have you ever had a stress fracture?		
15. Do you regularly use a brace, orthotics, or any other assistive device?		
18. Do any of your joints become painful, swollen, feel warm, or look red?		
19. Do you have any history of juvenile arthritis or connective tissue disease?		

20. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
21. Have you ever used an inhaler or taken asthma medicine?		
23. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
24. Do you have groin pain or a painful bulge or hernia in the groin area?		
25. Have you had infectious mononucleosis (mono) within the last month?		
26. Do you have any rashes, pressure sores, or other skin problems?		
27. Have you ever had a head injury or concussion?		
28. Do you have headaches with exercise?		
29. Have you ever had numbness, tingling, weakness, or paralysis in your arms or legs after being hit or falling?		
30. Have you ever become ill while exercising in the heat?		
31. Do you get frequent muscle cramps when exercising?		
32. Do you or someone in your family have sickle cell trait/disease?		
34. Have you had any problems or injuries with your eyes or vision?		
35. Do you wear protective eyewear, such as goggles or a face shield?		
36. Are you trying to or has anyone recommended that you gain or lose weight?		
37. Are you on a special diet or do you avoid certain types of food?		
38. Have you ever had an eating disorder?		
FEMALES ONLY	Yes	No
39. Have you ever had a menstrual period?		
40. When was your most recent menstrual period?		
Please Explain any "yes" Answers here:		