

Preparticipation Physical Examination Form

(Please type or print)

Student's Name _____ Birth Date _____ Sex _____ Grade _____

Last First Middle

City _____ School _____ Place of Birth _____

Student's Address _____

Street City Zip Telephone

Parent(s) or Guardian(s) Name _____

Address (if different than student) _____

Street City Zip Telephone

Family Physician's Name, Address, Telephone _____

History

This section is to be carefully completed by the student and his/her parent(s) or legal guardian(s) before participation in interscholastic athletics in order to help detect possible risks.

Explain "YES" answers below. Circle questions you don't know the answer to.

	Yes	No		Yes	No
1. Have you had a medical illness or injury since your last checkup or sports physical?	<input type="checkbox"/>	<input type="checkbox"/>	10. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have an ongoing or chronic illness?	<input type="checkbox"/>	<input type="checkbox"/>	11. Do you cough, wheeze or have trouble breathing during or after activity?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized overnight?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	12. 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)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you think you are in good health?	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear glasses, contacts or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any allergies (for example, to pollen, medicine, food, or stinging insect)?	<input type="checkbox"/>	<input type="checkbox"/>	14. Have you ever had a sprain, strain or swelling after injury?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had a rash or hives develop during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have you broken or fractured any bones or dislocated any joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<i>If yes, check the appropriate box and explain below.</i>		
Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Head <input type="checkbox"/> Upper Arm <input type="checkbox"/> Hand <input type="checkbox"/> Knee		
Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck <input type="checkbox"/> Elbow <input type="checkbox"/> Finger <input type="checkbox"/> Shin/calf		
Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Back <input type="checkbox"/> Forearm <input type="checkbox"/> Hip <input type="checkbox"/> Ankle		
Have you had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest <input type="checkbox"/> Wrist <input type="checkbox"/> Thigh <input type="checkbox"/> Foot		
Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder		
Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	15. Do you want to weigh more or less than you do now?	<input type="checkbox"/>	<input type="checkbox"/>
Is there a family history of heart problems in a close relative younger than age 50 (examples are enlarged heart, cardiomyopathy, long QT interval, abnormal EKG, abnormal heart rhythm)?	<input type="checkbox"/>	<input type="checkbox"/>	Do you lose weight regularly to meet weight requirements for your sport?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a severe heart infection (for example, myocarditis or pericarditis)?	<input type="checkbox"/>	<input type="checkbox"/>	16. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
Is there a family history of Marfan's Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	17. Record the dates of your most recent immunizations (shots) for:		
Has a physician ever denied or restricted your participation in sports for any heart problem?	<input type="checkbox"/>	<input type="checkbox"/>	Tetanus _____ Measles _____		
7. Have you ever had a severe viral infection within the last month (for example, mononucleosis)?	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B _____ Chickenpox _____		
8. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>	18. FEMALES ONLY		
9. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	When was your first menstrual period? _____		
Have you ever been knocked out, become unconscious or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>	When was your most recent menstrual period? _____		
Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	How much time do you usually have from the start of one period to the start of another? _____		
Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	How many periods have you had in the last year? _____		
Have you ever had numbness or tingling in your arms, hands, legs or feet?	<input type="checkbox"/>	<input type="checkbox"/>	What was the longest time between periods in the last year? _____		
Have you ever had a stinger, burner or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	19. ALL PARTICIPANTS		
			Explain "Yes" answers here: _____		

NOTE: CONSENT AND HIPAA RELEASE FORMS THAT MUST BE SIGNED BY BOTH THE PARENT AND THE STUDENT ARE ON A SEPARATE SHEET.

NOTE: History and All Consent Forms Must be Completed Prior to Physical Examination

Modified from the form approved by the American Academy of Family Physicians, the American Academy of Pediatrics, the American Medical Society for Sports Medicine, the American Orthopedic Society for Sports Medicine and the American Osteopathic Academy of Sports Medicine.

Physical Examination

(Please type or print)

Student's Name _____ Birth Date _____
Last First Middle

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

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

Normal

Abnormal Findings

Initials*

MEDICAL

	Normal	Abnormal Findings	Initials*
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			

MUSCULOSKELETAL

	Normal	Abnormal Findings	Initials*
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*Station-based examination only

Clearance

Cleared

Cleared after completing evaluation/rehabilitation for: _____

Not cleared for: _____ Reason: _____

Recommendations: _____

I certify that I have on this date examined this student and that, on the basis of the examination requested by the school authorities and the student's medical history as furnished to me, I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities (Note exceptions above).

 Physician's Name and Address (stamp or print)
 If the Physician's Assistant (P.A.) or Advanced Nurse Practitioner (A.N.P.) performed the exam, name and address of collaborating physician or physician group:

 Examiner's Signature Date

 Examiner's Telephone Number

NOTE: History and Consent Must be Completed Prior to Physical Examination