## ■ PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam					
Name			Date of birth		
Sex Age Grade Sci	100l <u> </u>		Sport(s)		
Medicines and Allergies: Please list all of the prescription and over	r-the-co	ounter m	redicines and supplements (herbal and nutritional) that you are currently	taking	
Do you have any allergies? ☐ Yes ☐ No If yes, please ide ☐ Medicines ☐ Pollens	ntify sp	ecific all	lergy below.  ☐ Food ☐ Stinging Insects		
Explain "Yes" answers below, Circle questions you don't know the ar	iswers i	to,			
GENERAL QUESTIONS  1. Has a doctor ever denied or restricted your participation in sports for any reason?	Yes	No	MEDICAL QUESTIONS  26. Do you cough, wheeze, or have difficulty breathing during or after exercise?	Yes	No
Do you have any ongoing medical conditions? If so, please identify below:     Asthma			27. Have you ever used an inhaler or taken asthma medicine?  28. Is there anyone in your family who has asthma?		
3. Have you ever spent the night in the hospital?			29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
Have you ever had surgery?	No. of the Land	F 430 - 1 - 42	30. Do you have groin pain or a painful bulge or hernia in the groin area?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No	31. Have you had infectious mononucleosis (mono) within the last month?		
Have you ever passed out or nearly passed out DURING or AFTER exercise?			32. Do you have any rashes, pressure sores, or other skin problems?  33. Have you had a herpes or MRSA skin infection?	-	
6. Have you ever had discomfort, pain, tightness, or pressure in your			34. Have you ever had a head injury or concussion?	<b></b>	1
chest during exercise? 7. Does your heart ever race or skip beats (irregular beats) during exercise?			35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
8. Has a doctor ever told you that you have any heart problems? If so,			36. Do you have a history of seizure disorder?		<u> </u>
check all that apply:			37. Do you have headaches with exercise?		· ·
☐ High cholesterol ☐ A heart infection			Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
S. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)  S. Kawasaki disease Other:  9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)			39. Have you ever been unable to move your arms or legs after being hit or falling?		
Do you get lightheaded or feel more short of breath than expected	ļ		40. Have you ever become ill while exercising in the heat?	-	
during exercise?			41. Do you get frequent muscle cramps when exercising?		
11. Have you ever had an unexplained seizure?			42. Do you or someone in your family have sickle cell trait or disease?		
Do you get more tired or short of breath more quickly than your friends during exercise?			43. Have you had any problems with your eyes or vision?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	44. Have you had any eye injuries?	-	ļ
13. Has any family member or relative died of heart problems or had an	iria.aa.	11/3/2010101	45. Do you wear glasses or contact lenses?		
unexpected or unexplained sudden death before age 50 (including			46. Do you wear protective eyewear, such as goggles or a face shield?  47. Do you worry about your weight?		
drowning, unexplained car accident, or sudden Infant death syndrome)?  14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan			48. Are you trying to or has anyone recommended that you gain or		
syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic			lose weight?  49. Are you on a special diet or do you avoid certain types of foods?		
polymorphic ventricular tachycardia?	<u></u>		50. Have you ever had an eating disorder?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			51. Do you have any concerns that you would like to discuss with a doctor?		
16. Has anyone in your family had unexplained fainting, unexplained			FEMALES ONLY		
seizures, or near drowning? BONE AND JOINT QUESTIONS	Yes	No	52. Have you ever had a menstrual period?  53. How old were you when you had your first menstrual period?		L
17. Have you ever had an injury to a bone, muscle, ligament, or tendon	163	NO.	54. How many periods have you had in the last 12 months?		
that caused you to miss a practice or a game?			Explain "yes" answers here		
18. Have you ever had any broken or fractured bones or dislocated joints?			populari you district the second second		
<ol> <li>Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?</li> </ol>					
20. Have you ever had a stress fracture?	<b> </b>				
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)					
22. Do you regularly use a brace, orthotics, or other assistive device?	$\vdash$				
23. Do you have a bone, muscle, or joint injury that bothers you?					
24. Do any of your joints become painful, swollen, feel warm, or look red?					
25. Do you have any history of juvenile arthritis or connective tissue disease?					
I hereby state that, to the best of my knowledge, my answers to	the abo	ve ques	stions are complete and correct.		
Signature of athlete Signature of	f parent/g	vardian _			

# PREPARTICIPATION PHYSICAL EVALUATION THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Ex	(am					
Name _				Date of birth		
Sex	Age	Grade	School	Sport(s)		
1. Type	of disability	•				
2. Date	of disability					
3. Classi	ification (if available)					•
4. Cause	of disability (birth, d	isease, accident/trauma, other)				
	ie sports you are inte	·				
			er, actorismone aparene College		Yes	No .
		ce, assistive device, or prostheti		TO A STOREGIST OF PROPERTY OF THE PROPERTY OF	5.7	acadamatan bicas
		ce or assistive device for sports	——————————————————————————————————————			
		ressure sores, or any other skin				
9. Do yo	u have a hearing loss	? Do you use a hearing aid?	·			
10. Do yo	u have a visual impai	rment?				
11. Do ya	u use any special dev	rices for bowel or bladder functi	on?			
12. Do yo	u have burning or dis	comfort when urinating?				
13. Have	you had autonomic d	ysreflexia?				
14. Have	you ever been diagno	sed with a heat-related (hyperth	ermia) or cold-related (hypothermia) illne	ss?		
15. Do yo	u have muscle spasti	city?				
16. Do you	u have frequent seizu	res that cannot be controlled by	medication?			
Explain "ye	es" answers here					
Please indi	cate if you have eve	er had any of the following.				
					Yes	No
	al instability		transa tan 1,000°, 200, 100°, 100 ani 100 ani 100°, 100°, 100°, 100°, 100°, 100°, 100°, 100°, 100°, 100°, 100°,		is: personal 222 deciplos	
	uation for atlantoaxia	l instability				
	joints (more than on					
Easy bleed	ling	·i				
Enlarged s	pleen					
Hepatitis	•					
Osteopenia	a or asteoporosis					
Difficulty o	entrolling bowel					
Difficulty c	ontrolling bladder		·			:
Numbness	or tingling in arms o	r hands				
Numbness	or tingling in legs or	feet				•••
Weakness	in arms or hands					
Weakness	in legs or feet			<u> </u>		
Recent cha	ange in coordination.					
Recent cha	ange in ability to walk					-
Spina bifid	a					
Latex aller	gy					
Explain "ye	s" answers here					
					<del> </del>	
		of my knowledge, my answen	s to the above questions are complete	and correct.		
Signature of a	thlete		Signature of parent/guardian		Dats	

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## PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

<ul> <li>Do you ew</li> <li>Do you fee</li> <li>Have you</li> <li>During the</li> <li>Do you dri</li> <li>Have you</li> <li>Have you</li> <li>Oo you we</li> </ul>	ditional quest al stressed of er feel sad, h el safe at you ever tried cig a past 30 day ink alcohol or ever taken ar ever taken ar ever taken ar	ions on mo ut or under opeless, do ir home or parettes, ch is, did you u r use any o nabolic ster ny supplem It, use a he	a lot of prepressed, residence ewing tobuse chewisther drugs roids or us lents to he lmet, and	essure? or anxious? ? acco, snuff ng tobacco ? ed any oth ulp you gair use condor	, or dip? , snuff, or dip? er performance s or lose weight o	r improve your	perform	nance?							
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Height			Wei				Male	☐ Female							
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MEDICAL					245418511311-1751		TATE	NORI	MAL	128.000	A	BNORMAL F	NDINGS.	erecing coercions	aki
arm span >	height, hype				ctus excavatum, fficiency)	arachnodactyly	1								
Eyes/ears/nose     Pupils equal     Hearing															
Lymph nodes			•												
Heart* • Murmurs (at				/alsalva)											
Pulses • Simultaneou	-														
Lungs															
Abdomen															
Genitourinary (	males only) <sup>b</sup>					-									
Skin  HSV, lesions  Neurologic	suggestive of	of MRSA, ti	nea corpo	ris											
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Back	· · · · · · · · · · · · · · · · · · ·														
Shoulder/arm															
Elbow/forearm														•	
Wrist/hand/fing															
Hip/thigh															
Knee															
Leg/ankie															
Foot/toes															
Functional  Duck-walk,	single leg ho	p													
*Consider GU exam	if in private se	tting. Having	third party	present is re	l cardiac history or commended, history of significan										
☐ Cleared for a	II snorte with	out restric	tion												
	•			ecommend	ations for further	r evaluation or to	reatmei	nt for							
☐ Not cleared															
	Pending fur	ther evalua	ation												
	For any spo	orts											•		
	- ;														
_															
Recommendation	ns														
have examine participate in the arise after the arto the athlete (a	ie sport(s) a thlete has b	s outlined een cleare	above. A ed for part	copy of th	e physical exar	n is on record	in my c	office and ca	ın be made	e available to	the school	at the reque	st of the par	rents. If cond	itions
Name of physicia	an (print/type	:)											Date		
Address												Phone			
												1 110116			or DO
Signature of phy	sıG80													, мо	or DO

\_\_ Date of birth \_\_\_

## ■ PREPARTICIPATION PHYSICAL EVALUATION CLEARANCE FORM

### WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION -- ATHLETIC PERMIT CARD

(Print or Type)

ALL STUDENTS PARTICIPATING IN INTERSCHOLASTIC ATHLETICS MUST HAVE THIS CARD ON FILE AT THEIR SCHOOL PRIOR TO PRACTICE OR PARTICIPATION

Physical examination taken April 1 and thereafter is vall year and the following school year.	ld for the following two school years; physical e	xamination taken before April 1 is v	alid only for the remainder of that school
NAME (Last)	(First)	(Middle Initial)	Date of Birth
Age Sex Grade School		City	
Present Address		Telephone	
□ Cleared without restriction □ Cleared, with t	the following qualifications:		
□ Not cleared □ Pending further evaluation □	□ For all sports □ For certain sports:		
Reason:			
Recommendations:		<u> </u>	
I have examined the above-named student and completed t in the sport(s) as outlined above. A copy of the physical exa has been cleared for participation, a physician may reso parents/guardians).	ım is on record in my office and can be made availa	ble to the school at the request of the	parents. If conditions arise after the athlete
Name of Physician (Print/Type)			
SIGNATURE OF LICENSED PHYSICIAN (MD OR DO)/APNE	3*•		
Clinic Name			<del></del>
Address/Clinic	City		State Zip Code
Telephone		Date of Examination	
* Physicians may authorize Nurse Practitioners or Physi		•	
Parents' Place of Employment			
Family Physician			
Name of Private Insurance Carrier		,	
Subscriber Member Name (Primary Insured)			
Emergency Information			
Allergies			
Other Information (medication, etc.)			
Immunizations		ccal; meningococcal; varicalla)	
I hereby give my permission for the above except those restricted on this card.	e named student to practice and compete	and represent the school in W	/IAA approved interscholastic sports
<ol> <li>Pursuant to the requirements of the Health II as "HIPAA"), I authorize health care provider may be attending an interscholastic event or appropriate school district personnel such as to the Athletic Director and/or other profession</li> </ol>	s of the student named above, including eme or practice, to disclose/exchange essential m a but not limited to: Principal, Athletic Director,	ergency medical personnel and of edical information regarding the Athletic Trainer, Team Physician,	her similarly trained professionals that injury and treatment of this student to Team Coach, Administrative Assistant
SIGNATURE OF PARENT/GUARDIAN	0	DAT	E