■ 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	School		Sport(s)						
Medicin currentl	•	: Please list all of the pr	escription and over-th	ne-counter medicin	nes and supplements (herbal and nutritional) that you are						
Do you	have any allergi	es? S Yes S No If yes	, please identify spec	ific allergy below.							
Medi	cines	⑤ Pollen	S	⑤ Food	Stinging Insects						
Explain "Y	es" answers belo	w. Circle questions you o	lon't know the answers	to.							

,			
GENERAL QUESTIONS	MEDICAL QUESTIONS	Yes	No
Has a doctor ever denied or restricted your sports for any reason?	26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
Do you have any ongoing medical condition identify below: Asthma Anemia Infections	27. Have you ever used an inhaler or taken asthma medicine?		
	28. Is there anyone in your family who has asthma?		
Have you ever spent the night in the hospital	29. Were you born without or are you missing a kidney, an		
4. Have you ever had surgery?	eye, a testicle (males), your spleen, or any other organ?		
HEART HEALTH QUESTIONS ABOUT YOU	30. Do you have groin pain or a painful bulge or hernia in the groin area?		
5. Have you ever passed out or nearly passed DURING or AFTER exercise?	31. Have you had infectious mononucleosis (mono) within the last month?		
Have you ever had discomfort, pain, tightne in your chest during exercise?	32. Do you have any rashes, pressure sores, or other skin problems?		
7. Does your heart ever race or skip beats (industrial during exercise?	33. Have you had a herpes or MRSA skin infection?		
Has a doctor ever told you have any heart p you that check all that	34. Have you ever had a head injury or concussion?		
apply: S A heart murmur High blood pressure	35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
S High cholesterol S Kawasaki disease Other:	36. Do you have a history of seizure disorder?		
Has a doctor ever ordered a test for your he	37. Do you have headaches with exercise?		
example, ECG/EKG, echocardiogram) 10. Do you get lightheaded or feel more short or	38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
expected during exercise? 11. Have you ever had an unexplained seizure	39. Have you ever been unable to move your arms or legs		
	after being hit or falling?		
12. Do you get more tired or short of breath mo your friends during exercise?	40. Have you ever become ill while exercising in the heat?		
HEART HEALTH QUESTIONS ABOUT YOUR	41. Do you get frequent muscle cramps when exercising?		
13. Has any family member or relative died of had an unexpected or unexplained sudden	42. Do you or someone in your family have sickle cell trait or disease?		
50 (including drowning, unexplained car acc infant death syndrome)?	43. Have you had any problems with your eyes or vision?		
14. Does anyone in your family have hypertropicardiomyopathy, Marfan syndrome, arrhythi			
ventricular cardiomyopathy, long QT syndro syndrome, Brugada syndrome, or catechola polymorphic ventricular tachycardia?			
Does anyone in your family have a heart pr pacemaker, or implanted defibrillator?	46. Do you wear protective eyewear, such as goggles or a face shield?		
passinaker, or implanted delibrinator:	47. Do you worry about your weight?		

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18. Have you ever had any broken or fractured benes or dislocated joints? 51. Do you have any concerns that you would like to discuss	
17. Have you ever had an injury to a bone, muscheditement, or tendon that caused you to miss a practice കൂടു പൂട്ടുയ്ക്ക് ever had an eating disorder?	
BONE AND JOINT QUESTIONS 49. Are you on a special die or do you avoid certain types of	
16. Has anyone in your family had unexplained at tinge you trying to or has anyone recommended that you gain or lose weight?	

Sport(s)

School _

Grade

Sex _

Age

1. Type of disability		
2. Date of disability		
3. Classification (if available)		
4. Cause of disability (birth, disease, accident/trauma, other)		
5. List the sports you are interested in playing		
	Yes	No
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		
Explain "yes" answers here		
Please indicate if you have ever had any of the following.		
Todae maisae myse mare ever mad any or the relief ming.	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		

Numbness or tingling in legs or feet

Weakness in arms or hands
Weakness in legs or feet

Recent change in coordination				
Recent change in ability to walk				
Spina bifida				
Latex allergy				
Explain "yes" answers here				<u>I</u>
I hereby state that, to the best of my knowledge, my answers to the above quest	tions are complete an	nd correct.		
Signature of athlete Signature of parer	nt/guardian		Date	
PHYSICIAN REMINDERS 1. Consider additional questions on more sensitive issues • Do you feel stressed out or under a lot of pressure? • Do you ever feel sad, hopeless, depressed, or anxious? • Do you feel safe at your home or residence? • Have you ever tried cigarettes, chewing tobacco, snuff, or dip? • During the past 30 days, did you use chewing tobacco, snuff, or dip? • Do you drink alcohol or use any other drugs? • Have you ever taken anabolic steroids or used any other performance supp • Have you ever taken any supplements to help you gain or lose weight or im • Do you wear a seat belt, use a helmet, and use condoms?		Date of	birth	
Consider reviewing questions on cardiovascular symptoms (questions 5–14). EXAMINATION				
Height Weight	⑤ Male ⑤ F	Female		
BP / (/) Pulse	Vision R 20		0/ s) N
Corrected © Y			•	••
MEDICAL	NORMAL	ABNORMAL	FINDINGS	
Appearance Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)				
Eyes/ears/nose/throat Pupils equal Hearing				
Lymph nodes				
Heart a • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)				
Pulses • Simultaneous femoral and radial pulses				
Lungs				

Abdomen

Genitourinary (males only)^b

Skin

HSV, lesions suggestive of MRSA, tinea corporis

Neurologic														
MUSCULO	SKELETAL													
Neck														
Back														
Shoulder/ar	m													
Elbow/forea	arm													
Wrist/hand/	fingers													_
Hip/thigh														_
Knee														_
Leg/ankle														_
Foot/toes														_
	x, single leg ho													
history or examis recommende	6, echocardiogram n. bConsider GU o ed. cConsider cog ory of significant	exam if in priv gnitive evaluat	ate setting. H	aving third party	present	·								
©Cleared for	all sports with	out restriction	on											
@Cleared	for all	sports	without	restriction	with	recommend	dations	for	further	evalua	tion	or	treatment	for
	©Not cle											6	For certain sp	orts
	Reason													
Recommend	ations													
I have exam	ined the abov	/e-named s	tudent and	completed t	he prepartion	ipation ph	ysical eva	luation.	The ath	lete does	not pre	sent a	pparent clini	al
contraindica	itions to prac	tice and l h	ave examin	ed the above-	named stude	ent and con	npleted the	e prepart	icipation	physical e	valuation	n. The	athlete does	not
present appa office and c physical exar for participa arise after the are complete to the athlete	arent clinical co an be made a m is on record tion, a physic e athlete has b ly explained to e (and parents	ontraindication available to in my office in may respect the athlete s/guardians	the schoo and can be scind the cl for participa (and parent	ice and partic I at the reque made available earance until ation, the phys	cipate in the est of the pa le to the scho I the probler	sport(s) as arents. If cool at the re- on is resolve	s outlined onditions quest of the ed and the	above. participate parents potenti	A copy of te in the s. If conditial conse	f the physport(s) as arise afte quences	sical exa s outlined r the ath are com	am is d abov lete h pletel	on record in re. A copy of as been clead y explainedtion	ny the ed
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■ 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 $\underline{\text{PRIOR TO}}$

NAME (Last)					(First)	(Middle Initial) Da	ate of Birt
	 Age	Sex	Grade	School		City	
					Present Addre	ss	
					Tele	ephone	
		q Cleare	ed without rest	riction	q Cleared, with the following qua	lifications:	
Not cleared	l q P e	ending further	evaluation	q For all sp	orts q For certain sports:		
Reason:							
	ations:						
Recommenda have examir contraindicat available to t clearance un	ned the abo tions to pra he school a til the probl	ctice and parti It the request of Iem is resolved	icipate in the sports.	oort(s) as outli If conditions a	articipation physical evaluation. The athle ned above. A copy of the physical exam i rise after the athlete has been cleared for nces are completely explained to the athl	is on record in my office and can be r participation, a physician may resc	made
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Fami	ly Physiciar	ı			Family Dentist			
Name	e of	Private	Insurance	Carrier				Telephon
				Subscriber	Member	Name	(Primary	Insured
						<u>Er</u>	nergency Information	
•								
Other	Informatio	n (medicatior	n, etc.)					
		-		asles, mumps, rubeq Up to to date - specify	•			elitis;
	pt those reserscholastic		s card.I hereby g	ive my permission for the	above named student to	practice and compete a	and represent the school	in rST approve
2. Pu	ırsuant to th	e requirements	s of the Health Ins	urance Portability and Acco	ountability Act of 1996 and	the regulations promulga	ated thereunder (coas "Hli	PAA"), I authoriz
he	alth care p	roviders of the	e student named	above, including emerge	ncy medical personnel ar	nd other similarly traine	ed professionals thatmay	be attending a
int	erscholastic	event or prac	ctice, to disclose/e	exchange essential medica	l information regarding the	e injury and treatment of	this student tolectively k	nown appropriat
sc	hool district	personnel suc	ch as but not limite	ed to: Principal, Athletic Dire	ector, Athletic Trainer, Tea	m Physician, Team Coa	ich, Administrative Assis-t	ant to the Athleti
Dii	rector and/c	r other profess	sional health care	providers, for purposes of	treatment, emergency car	re and injury record-kee	ping.	
SICN	IATLIDE OE	DADENT/OU	ADDIAN				D.175	

* Physicians may authorize Nurse Practitioners to stamp this card with the physician's signature or the name of the clinic with which the physician is

affiliated.