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) _____

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

_____

_____

_____

Do you have any allergies? ⑤ Yes ⑤ No If yes, please identify specific allergy below.

⑤ Medicines ⑤ Pollens ⑤ Food ⑤ Stinging Insects

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

GENERAL QUESTIONS
1. Has a doctor ever denied or restricted your sports for any reason?
2. Do you have any ongoing medical conditior identify below: ⑤ Asthma ⑤ Anemia (Infections
3. Have you ever spent the night in the hospita
4. Have you ever had surgery?
HEART HEALTH QUESTIONS ABOUT YOU
5. Have you ever passed out or nearly passed DURING or AFTER exercise?
6. Have you ever had discomfort, pain, tightne in your chest during exercise?
7. Does your heart ever race or skip beats (during exercise?
8. Has a doctor ever told you have any heart p you that check all that apply: ⑤ A heart murmur ⑤ High blood pressure ⑤ High cholesterol ⑤ A heart infection ⑤ Kawasaki disease Other: _____
9. Has a doctor ever ordered a test for your he example, ECG/EKG, echocardiogram)
10. Do you get lightheaded or feel more short c expected during exercise?
11. Have you ever had an unexplained seizure
12. Do you get more tired or short of breath mo your friends during exercise?
HEART HEALTH QUESTIONS ABOUT YOUR
13. Has any family member or relative died of h had an unexpected or unexplained sudden 50 (including drowning, unexplained car acc infant death syndrome)?
14. Does anyone in your family have hypertrop cardiomyopathy, Marfan syndrome, arrhythi ventricular cardiomyopathy, long QT syndrc syndrome, Brugada syndrome, or catechola polymorphic ventricular tachycardia?
15. Does anyone in your family have a heart pr pacemaker, or implanted defibrillator?

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		

16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or surgery?		
20. Have you ever had a stress fracture?		
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?		
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?		

48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

_____
_____
_____
_____
_____
_____
_____
_____
_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____
Date _____

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Preparticipation Physical Evaluation

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam
_____

Name _____ Date of birth
_____

Sex _____ Age _____ Grade _____ School _____ Sport(s)
_____

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.

	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

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

Preparticipation Physical Evaluation

PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

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 supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height Weight	⑤ Male ⑤ Female	
BP / (/) Pulse Corrected ⑤ Y	Vision R 20/ L 20/	⑤ N
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 [c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam. [b]Consider GU exam if in private setting. Having third party present is recommended. [c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

⑥Cleared for all sports without restriction

⑥Cleared for all sports without restriction with recommendations for further evaluation or treatment for

_____

_____

_____ ⑥Not cleared

⑥Pending further evaluation

⑥For any sports

⑥For certain sports

_____

Reason

_____

Recommendations

_____

_____

_____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and **participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions** participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If condi**arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained** tions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).
to the athlete (and parents/guardians).

Name of physician (print/type) _____

Date _____ Address

_____ Phone

_____

Signature of physician

_____, MD or DO MD or DO/PA/APNP

_____

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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 PRIOR TO PRACTICE OR PARTICIPATION

Physical examination taken April 1 and thereafter is valid for the following two school years; physical examination taken before April 1 is valid only for the remainder of that school year and the following school year.

NAME (Last) _____ (First) _____ (Middle Initial) _____ Date of Birth _____

Age _____ Sex _____ Grade _____ School _____ City

_____ Present Address

_____ Telephone _____

q **Cleared without restriction** q **Cleared, with the following qualifications:**

_____

_____

_____

q **Not cleared** q **Pending further evaluation** q **For all sports** q **For certain sports:**

_____

Reason:

_____

Recommendations:

_____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of Physician (Print/Type)

_____

SIGNATURE OF LICENSED PHYSICIAN (MD OR DO)/PA/APNP*:

_____

Clinic Name

_____

Address/Clinic _____ City _____ State _____ Zip Code _____

Telephone _____ Date of Examination

_____

***** 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.

Parents' Place of Employment _____

Family Physician _____ Family Dentist _____

Name of Private Insurance Carrier _____ Telephone

_____ Subscriber Member Name (Primary Insured)

_____ **Emergency Information**

Allergies _____

Other Information (medication, etc.) _____

(**Immunizations** e.g., tetanus/diphtheria; measles, mumps, rubeq **Up to date (see attached documentation)** la; hepatitis A, B; influenza; poliomyelitis; pneumococcal; meningococcal; variceq **Not up to date - specify** _____la)

1. cept those restricted on this card.I hereby give my permission for the above named student to practice and compete and represent the school in rST approved interscholastic sports ex-

2. Pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder (coas "HIPAA"), I authorize

health care providers of the student named above, including emergency medical personnel and other similarly trained professionals thatmay be attending an

interscholastic event or practice, to disclose/exchange essential medical information regarding the injury and treatment of this student tolectively known appropriate

school district personnel such as but not limited to: Principal, Athletic Director, Athletic Trainer, Team Physician, Team Coach, Administrative Assis-tant to the Athletic

Director and/or other professional health care providers, for purposes of treatment, emergency care and injury record-keeping.

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____