PRE-PARTICIPATION PHYSICAL EVALUATION

To be completed by athlete and parent:

Date: ____

Student-Athlete's Name: ____
Last *First* *Middle*

Address: ____
Street

____ Phone (401) ______________________
City/State *Zip*

School: ______________________________ Grade: ______________________

Date of Birth: ______________________________ Age ____________ Sex __________

Emergency Contact Person: ____

Emergency Phone: (____) ______________________

Family Doctor: ____

Address: ____
Street

____
City/State *Zip*

Phone: (____) ____

Pre-participation History and Physical Exam

<u>**HISTORY**</u>

General	**Yes**	**No**
1. Have you had a medical illness or injury since your last check up or sports physical?	___	___
2. Do you have an ongoing or chronic illness? ________________________	___	___
3. Have you ever been hospitalized overnight?	___	___
4. Have you ever had surgery?	___	___
5. Are you currently taking any prescription or non-prescription (over the counter) medications or pills?	___	___
a. prescription ________________________	___	___
b. non-prescription ________________________	___	___
(over the counter)	___	___
6. Do you have any allergies (for example: to pollen, medicine, or stinging insects)? If yes, which one(s)? ____	___	___
7. Do you have any dental prosthetic devices (i.e., bridges, crowns))	___	___
8. Have you had any problems with your eyes or vision? ___________________________	___	___
9. Do you wear glasses, contacts, or protective eyewear? ___________________________	___	___
10. Do you have any current skin problems? _______________________________________	___	___
11. Have you ever fainted or become ill from exercising in the heat?	___	___
12. If you smoke, how many packs per day? ________		
13. Do you have only one of a normally paired organ (i.e. kidney, lung, eye, testicle)? If yes, which one(s)? _______________________________________	___	___

Heart	**Yes**	**No**
1. Have you ever passed out during or after exercise?	___	___
2. Have you ever been dizzy after exercise?	___	___
3. Have you ever had chest pain during or after exercise?	___	___
4. Have you ever had racing of your heart or skipped heartbeats?	___	___
5. Have you ever been told you have a heart murmur?	___	___
6. Has any family member or relative died of heart problems or of sudden death before age 50?	___	___
7. Have you had a viral infection (for example: mononucleosis) within the last year? If yes, what? ________________________________	___	___
8. Has a physical ever denied or restricted your participation in sports for any heart problems?	___	___

Lung	**Yes**	**No**
1. Do you cough, wheeze, or have trouble breathing during or after activity?	___	___
2. Do you have asthma?	___	___
3. Do you use an inhaler?	___	___

Musculo-Skeletal	**Yes**	**No**
1. 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)?	___	___
2. Have you ever had a sprain, strain, or swelling after injury which prevented you from participation? ____	___	___
3. Have you broken or fractured any bones or dislocated any joints? ____		

Head | **Yes** | **No**

Head	Yes	No
1. Have you had a head injury or a concussion?	___	___
2. Have you ever been knocked out, become unconscious, or lost your memory?	___	___
3. Have you ever had a seizure?	___	___
4. Have you ever had a stinger, burner, or numbness in your arms, hands, legs or feet?	___	___
If yes, which one(s)? ____		

Nutrition	Yes	No
1. Do you skip meals during the day?	___	___
2. Do you use laxatives, diuretics, or stimulants to control your weight?	___	___
If yes, which one(s)? _______________________________________		
3. Do you feel disgusted, depressed, or guilty about your eating?	___	___
4. Do you self-induce vomiting after eating?	___	___
5. Do you restrict certain types of foods?	___	___
If yes, which one(s)? _______________________________________		
6. Have you ever taken nutritional supplements?	___	___
If yes, which one(s)? _______________________________________		
7. Do you have a food allergy?	___	___
If yes, which one(s)? _______________________________________		
8. Do you want to weigh more or less than you do now?	___	___

FEMALES ONLY

1. When was your last menstrual period? ___________
2. How often do your periods occur? ___________
3. Have you ever gone 4 months without getting a period? ___________

Parental Permission and Authorization for Treatment

We hereby give our consent for ____________________________________ to represent his/her school in interscholastic athletics. If in the event of injury or accident either en route to the event, at the event, or en route back from the event, we also give our consent for the school to obtain any and all medical care that is deemed reasonably necessary for the welfare of the student. We realize that all reasonable efforts will be made to contact us if the above does occur.

We further state that we have completed that part of this form which requires us to list all previous injuries or conditions that are known to us and that the form is completed correct and true.

Name of Primary Medical Insurance: ____

Policy Number: _____________________________________ Expiration Date: ______________________________

Parent or Guardian (PRINT): ____

Signature of Parent or Guardian: ____

Date: ____________________________

NAME: ___________________________________

PHYSICAL EXAMINATION

SPORT(s): __________________________________

Age: _______________

Date of Exam:______________________________

Height ______ Weight ______
Pulse _______ BP ______, ______, ______
Vision R ______ L ______ Corrected: Y N

	Normal	Explanation
Medical		
General		
Skin		
HEENT		
Lymph Nodes		
Heart		
Lungs		
Abdomen		
Genitalia (males only)		
Pulses		
Musculo-Skeletal		
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Calf		
Ankle/Foot		
Neurologic		

Immunizations

1. When was your last tetanus shot? __________________
2. When was the date of your measles immunization? __________________

Identified Problems:

1. ____
2. ____
3. ____

Review by Physician:

____ No Athletic Participation
____ Limited Participation, e.g., ______________________________________
____ Clearance Withheld Until: ______________________________________
____ Full Unlimited Participation

Athlete requesting clearance in the following sport(s): ________________________________

Cleared: Yes / / No / /

Recommendations ____

Name of Physician, NP, or PA ____________________________________ Date _____________

Address ____ Phone _____________

Signature of Physician ____, MD or DO

rev. 02/00 (Physician's signature required if examination performed by nurse practitioner or physician's assistant)