PREPARTICIPATION PHYSICAL EXAMINATION

Name_____DOB_____

Height____ Weight____ % Body Fat (optional)_____ Pulse_____ BP___/____ (____/____,____/____)

Vision: R20/_____L20/_____ Corrected: Y / N Pupils: ☐ Equal ☐ Unequal

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS
Appearance			
Ears/Eyes/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Arm/Back/Shoulder			
Elbow/Forearm			
Hip/Thigh			
Knee			
Ankle/Leg			
Foot			

PHYSICAL CLEARANCE

☐ **CLEARED**

☐ **NOT CLEARED** / Reason: _____

_____

_____

☐ Recommendation(s): _____

_____

Physician's Name (***stamp required***)_____**Date of Exam**_____

Address_____Phone_____

Physician's Signature_____, M.D. or O.D.

****** IMPORTANT NOTE:* COMPLETED FORMS MUST BE DATED, STAMPED & SHOW STUDENT'S CLEARANCE STATUS. *INCOMPLETE FORMS WILL NOT BE ACCEPTED.* *****

PREPARTICIPATION PHYSICAL EXAMINATION

DATE OF EXAM_____

Name_____SEX_____AGE_____DOB_____
Address_____
Personal Physician's Name_____

In case of emergency, please contact the following person:
Name_____Relationship_____
Contact Phone Number(s)_____

Please explain "Yes" answers below, and circle the questions you don't know the answer to.	YES	NO	*Please explain "Yes" answers below, and circle the questions you don't know the answer to.*	YES	NO
1. Have you had a medical illness or injury since your last checkup/sports physical?	☐	☐	25. Have you ever had a stinger, burner, or pinched nerve?	☐	☐
2. Do you have an ongoing or chronic illness?	☐	☐	26. Have you ever become ill from exercising in the heat?	☐	☐
3. Have you ever been hospitalized overnight?	☐	☐	27. Do you cough, wheeze, or have trouble breathing during or after activity?	☐	☐
4. Have you had surgery?	☐	☐	28. Do you have asthma?	☐	☐
5. Are you currently taking any prescription or nonprescription (over the counter) medications/pills or using an inhaler?	☐	☐	29. Do you have seasonal allergies that require medical treatment?	☐	☐
6. Have you ever taken any supplements or vitamins to help you gain weight or improve your performance?	☐	☐	30. Do you have any special corrective or protective equipment or devices that aren't usually used for your sport or position (i.e. knee brace, special neck roll, foot orthotics, teeth retainer, hearing aid?	☐	☐
7. Do you have any allergies (i.e. pollen, medicine, food, or stinging insects)?	☐	☐	31. Have you had any problems with your eyes or vision?	☐	☐
8. Have you ever had a rash or hives develop during or after exercises?	☐	☐	32. Do you wear glasses, contacts, or protective eyewear?	☐	☐
9. Have you ever been dizzy during or after exercise?	☐	☐	33. Have you ever had a sprain, strain, or swelling after injury?	☐	☐
10. Have you ever had chest pain during or after exercise?	☐	☐	34. Have you broken or fractured any bones or dislocated any joints?	☐	☐
11. Have you ever passed out during or after exercise?	☐	☐	35. Have you ever had any other problems with pain or swelling in muscles, tendons, bones, or joints?	☐	☐
12. Do you get tired more quickly than your friends do during exercise?	☐	☐	*If yes, please check the appropriate box and explain below.*		
13. Have you ever had racing of your heart or skipped heartbeats?	☐	☐	☐ Head ☐ Elbow ☐ Hip ☐ Neck ☐ Forearm ☐ Thigh ☐ Back ☐ Wrist ☐ Knee ☐ Chest ☐ Hand ☐ Calf ☐ Shoulder ☐ Finger ☐ Ankle ☐ Upper Arm ☐ Skin ☐ Foot		
14. Have you had high blood pressure or cholesterol?	☐	☐			
15. Have you ever been told you have a heart murmur?	☐	☐	36. Do you want to weigh more or less than you do now?	☐	☐
16. Has any family member or relative died of heart problems or sudden death before age 50?	☐	☐	37. Do you lose weight regularly to meet the weight requirements for your sport?	☐	☐
17. Have you had a severe viral infection (i.e. myocarditis or mononucleosis) within the last month?	☐	☐	38. Do you feel stressed out?	☐	☐
18. Has a physician ever denied or restricted your participation in sports for heart problems?	☐	☐	39. Please record the dates of your most recent immunizations (shots) for the following: Tetanus_____ Measles_____ Hepatitis B_____ Chicken Pox_____		
19. Do you have any current skin problems (i.e. itching, rashes, acne, warts, fungus, blisters)?	☐	☐	**FOR FEMALES ATHLETES ONLY**		
20. Have you ever had a head injury or concussion?	☐	☐	40. When was your first menstrual period? _____		
21. Have you ever been knocked out, become unconscious, or lost your memory?	☐	☐	41. When was your most recent period? _____		
22. Have you ever had a seizure?	☐	☐	42. How much time do you usually have from the start of one period to the start of another? _____		
23. Do you have frequent or severe headaches?	☐	☐	43. How many periods have you had in the last year?_____		
24. Have you ever had numbness or tingling in your arms, hands, legs, or feet?	☐	☐	44. What was the longest time between periods in the last year? _____		
Please explain any "Yes" answers here:					

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

Athlete's Signature_____Date_____
Parent/Guardian's Signature_____ Date_____