PREPARTICIPATION PHYSICAL EVALUATION --PHYSICAL EXAMINATION

As a minimum requirement, this **Physical Examination Form** must be completed after **June 1, 2012.**

Student's Name _____ Sex _____ Age _____

Date of Birth _____ Height _____ Weight _____

Pulse _____ BP____/____ (____/____, ____/____) Vision R 20/_____ L 20/_____ Corrected: Y N Pupils:

Equal _____ Unequal _____

	NORMAL	ABNORMAL FINDINGS
MEDICAL		
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart-Auscultation of the heart in the supine position.		
Heart-Auscultation of the heart in the standing position.		
Pulses		
Lungs		
Abdomen		
Genitalia (males only)		

MUSCULOSKELETAL

Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		

CLEARANCE FOR INTERCOLLEGIATE ATHLETICS (check one)

_____ Cleared

_____ Cleared after completing evaluation/rehabilitation for:

_____

_____ Not cleared for: _____

Reason: _____

Recommendations: _____

Dr. Name: _____ Signature: _____

Address/Phone: _____ Date of **Examination:** _____

_____

PREPARTICIPATION PHYSICAL EVALUATION – MEDICAL HISTORY

Student's Name: _____ Sex: _____ Age _____ Date of Birth: _____

Explain *"YES"* answers in the box below. Circle questions you don't know the answers to:** ***Any YES answer to questions 1, 2, 5, 6, 10 or 13 requires further medical evaluation which may include a physical examination. Written clearance from a physician, physician assistant, chiropractor, or nurse practitioner is required before any participation in any practices, games or matches.***

Yes No

1. Have you had a medical illness or injury since your last check up or sports physical?
2. Have you been hospitalized overnight in the past year?
3. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?
4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?
5. Have you ever passed out during or after exercise?
   Have you ever had chest pain during or after exercise?
   Do you get tired more quickly than your friends do during exercise?
   Have you ever had racing of your heart or skipped heartbeats?
   Have you had high blood pressure or high cholesterol?
   Have you ever been told you have a heart murmur?
   Has any family member or relative died of heart problems or of sudden unexpected death before age 50?
   Has any family member been diagnosed with enlarged heart, hypertrophic cardiomyopathy, long QT syndrome, Marfan's syndrome, or abnormal heart rhythm?
   Have you had a severe viral infection (i.e., myocarditis or mononucleosis) within the last month?
   Has a physician ever denied or restricted your participation in sports for any heart problems?
6. Have you ever had a head injury or concussion?
   Have you ever been knocked out, become unconscious, or lost your memory?
   If yes, how many times? _____ When was the last concussion? _____
   How severe was each one? (Explain below)
   Have you ever had a seizure?
   Do you have frequent or severe headaches?
   Have you ever had a stinger, burner or pinched nerve?
7. Have you ever become ill from exercising in the heat?
8. Have you ever gotten unexpectedly short of breath with exercise?
   Do you cough, wheeze, or have trouble breathing during or after activity?
   Do you have asthma?
   Do you have seasonal allergies that require medical treatment?
9. Have you had any problems with your eyes or vision?
10. Are you missing any paired organs?
11. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (i.e., knee brace, foot orthotics, retainer on your teeth, hearing aid, contact lenses)?
12. Have you ever had a sprain, strain, or swelling after injury?
    Have you broken or fractured any bones or dislocated any joints?
    Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?
    If yes, check appropriate box and explain below.

Head	Elbow	Hip	Thigh	Knee	Upper Arm	
Neck	Forearm	Shin/Calf	Ankle	Foot	Shoulder	
Back	Wrist	Hand	Finger	Chest		

13. Are you under a doctor's care?

****EXPLAIN "YES" ANSWERS IN THE BOX BELOW** (Attach another sheet if necessary)

_____

_____

_____

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

Student Signature: _____ Parent/Guardian Signature: _____ Date: _____

THIS <u>FORM</u> MUST BE ON FILE <u>PRIOR</u> TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE OR CONTEST!