

PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

- 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?
- Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height _____	Weight _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
BP _____ / _____ (_____ / _____)	Pulse _____	Vision R 20/ _____ L 20/ _____ Corrected <input type="checkbox"/> Y <input type="checkbox"/> 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* • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only) [†]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic [‡]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

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

- Cleared for all sports without restriction
- Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____
- Not cleared
- Pending further evaluation
 - For any sports
 - 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, the 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) _____ Date _____
 Address _____ Phone _____
 Signature of physician _____, MD or DO

■ PREPARTICIPATION PHYSICAL EVALUATION CLEARANCE FORM

Name _____ Sex M F Age _____ Date of birth _____

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

Not cleared
 Pending further evaluation
 For any sports
 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, the 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) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

EMERGENCY INFORMATION

Allergies _____

Other information _____

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? Yes No If yes, please identify specific allergy below.
 Medicines Pollens Food Stinging Insects

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

GENERAL QUESTIONS		Yes	No	MEDICAL QUESTIONS		Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?				26. Do you cough, wheeze, or have difficulty breathing during or after exercise?			
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____				27. Have you ever used an inhaler or taken asthma medicine?			
3. Have you ever spent the night in the hospital?				28. Is there anyone in your family who has asthma?			
4. Have you ever had surgery?				29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?			
HEART HEALTH QUESTIONS ABOUT YOU		Yes	No	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 out DURING or AFTER exercise?				31. Have you had infectious mononucleosis (mono) within the last month?			
6. Have you ever had discomfort, pain, tightness, or pressure 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 (irregular beats) during exercise?				33. Have you had a herpes or MRSA skin infection?			
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other: _____				34. Have you ever had a head injury or concussion?			
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)				35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?			
10. Do you get lightheaded or feel more short of breath than expected during exercise?				36. Do you have a history of seizure disorder?			
11. Have you ever had an unexplained seizure?				37. Do you have headaches with exercise?			
12. Do you get more tired or short of breath more quickly than your friends during exercise?				38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?			
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		Yes	No	39. Have you ever been unable to move your arms or legs after being hit or falling?			
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?				40. Have you ever become ill while exercising in the heat?			
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?				41. Do you get frequent muscle cramps when exercising?			
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?				42. Do you or someone in your family have sickle cell trait or disease?			
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?				43. Have you had any problems with your eyes or vision?			
BONE AND JOINT QUESTIONS		Yes	No	44. Have you had any eye injuries?			
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?				45. Do you wear glasses or contact lenses?			
18. Have you ever had any broken or fractured bones or dislocated joints?				46. Do you wear protective eyewear, such as goggles or a face shield?			
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?				47. Do you worry about your weight?			
20. Have you ever had a stress fracture?				48. Are you trying to or has anyone recommended that you gain or lose weight?			
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)				49. Are you on a special diet or do you avoid certain types of foods?			
22. Do you regularly use a brace, orthotics, or other assistive device?				50. Have you ever had an eating disorder?			
23. Do you have a bone, muscle, or joint injury that bothers you?				51. Do you have any concerns that you would like to discuss with a doctor?			
24. Do any of your joints become painful, swollen, feel warm, or look red?				FEMALES ONLY			
25. Do you have any history of juvenile arthritis or connective tissue disease?				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 _____

Concussion Information

According to the article "Concussion" by the Mayo Clinic Staff,¹ a concussion is defined and has symptoms as follows:

Definition:

A concussion is a traumatic brain injury that alters the way your brain functions. Effects are usually temporary, but can include problems with headache, concentration, memory, judgment balance and coordination.

Although concussions usually are caused by a blow to the head, they can also occur when the head and upper body are violently shaken. These injuries can cause a loss of consciousness, but most concussions do not. Because of this, some people have concussions and don't realize it.

Concussions are common, particularly if you play a contact sport, such as football. But every concussion injures your brain to some extent. This injury needs time and rest to heal properly. Luckily, most concussive traumatic brain injuries are mild, and people usually recover fully.

Symptoms:

The signs and symptoms of a concussion can be subtle and may not be immediately apparent. Symptoms can last for days, weeks or even longer.

The most common symptoms after a concussive traumatic brain injury are headache, amnesia and confusion. The amnesia, which may or may not be preceded by a loss of consciousness, almost always involves the loss of memory of the impact that caused the concussion.

Signs and symptoms may include:

- * Headache or a feeling of pressure in the head
- * Temporary loss of consciousness
- * Confusion or feeling as if in a fog
- * Amnesia surrounding the traumatic event
- * Dizziness or "seeing stars"
- * Ringing in the ears
- * Nausea or vomiting
- * Slurred speech
- * Fatigue

The well-being of its Student Athletes is of paramount importance to the School. Coaches are trained annually in recognizing the signs and symptoms of concussions and are required immediately to remove from practice, conditioning, or a game any Student Athlete who shows such signs. Student Athletes will not be permitted to return until a Health Care Provider has either ruled out a concussion or determines the Student Athlete capable of returning. In no instance will a Student Athlete with a diagnosed concussion return the same day.

PRINTED Student Name: _____

Signature of Student: _____ Date: _____

PRINTED Parent Name: _____

Signature of Parent: _____ Date: _____

Medical Insurance Information

Insurance Company _____

Name of Card Holder _____

Policy # _____

Group # _____

Customer Service Phone # _____