

Preparticipation Physical Evaluation

HISTORY

DATE OF EXAM _____

Name _____ Sex _____ Age _____ Date of birth _____
 Grade _____ School _____ Sport(s) _____
 Address _____
 Personal physician _____ Phone _____
In case of emergency, contact
 Name _____ Relationship _____ Phone (H) _____

Explain "Yes" answers below. Circle the number if you don't know the answers.

- | | Yes | No |
|------------------------------------------------------------------------------------------------------------------------------|-----------------------|-----------------------|
| 1. Have you had a medical illness or injury since your last check up or sports physical? | <input type="radio"/> | <input type="radio"/> |
| Do you have an ongoing or chronic illness? | <input type="radio"/> | <input type="radio"/> |
| 2. Have you ever been hospitalized overnight? | <input type="radio"/> | <input type="radio"/> |
| Have you ever had surgery? | <input type="radio"/> | <input type="radio"/> |
| 3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler? | <input type="radio"/> | <input type="radio"/> |
| Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? | <input type="radio"/> | <input type="radio"/> |
| 4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? | <input type="radio"/> | <input type="radio"/> |
| Have you ever had a rash or hives develop during or after exercise? | <input type="radio"/> | <input type="radio"/> |
| 5. Have you ever passed out during or after exercise? | <input type="radio"/> | <input type="radio"/> |
| Have you ever been dizzy during or after exercise? | <input type="radio"/> | <input type="radio"/> |
| Have you ever had chest pain during or after exercise? | <input type="radio"/> | <input type="radio"/> |
| Do you get tired more quickly than your friends do during exercise? | <input type="radio"/> | <input type="radio"/> |
| Have you ever had racing of your heart or skipped heartbeats? | <input type="radio"/> | <input type="radio"/> |
| Have you had high blood pressure or high cholesterol? | <input type="radio"/> | <input type="radio"/> |
| Have you ever been told you have a heart murmur? | <input type="radio"/> | <input type="radio"/> |
| Has any family member or relative died of heart problems or of sudden death before age 50? | <input type="radio"/> | <input type="radio"/> |
| Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? | <input type="radio"/> | <input type="radio"/> |
| Has a physician ever denied or restricted your participation in sports for any heart problems? | <input type="radio"/> | <input type="radio"/> |
| 6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? | <input type="radio"/> | <input type="radio"/> |
| 7. Have you ever had a head injury or concussion? | <input type="radio"/> | <input type="radio"/> |
| Have you ever been knocked out, become unconscious, or lost your memory? | <input type="radio"/> | <input type="radio"/> |
| Have you ever had a seizure? | <input type="radio"/> | <input type="radio"/> |
| Do you have frequent or severe headaches? | <input type="radio"/> | <input type="radio"/> |
| Have you ever had numbness or tingling in your arms, hands, legs, or feet? | <input type="radio"/> | <input type="radio"/> |
| Have you ever had a stinger, bumer, or pinched nerve? | <input type="radio"/> | <input type="radio"/> |
| 8. Have you ever become ill from exercising in the heat? | <input type="radio"/> | <input type="radio"/> |
| 9. Do you cough, wheeze, or have trouble breathing during or after activity? | <input type="radio"/> | <input type="radio"/> |
| Do you have asthma? | <input type="radio"/> | <input type="radio"/> |
| Do you have seasonal allergies that require medical treatment? | <input type="radio"/> | <input type="radio"/> |

- | | Yes | No |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|---------------------------------|
| 10. 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, hearing aid)? | <input type="radio"/> | <input type="radio"/> |
| 1. Have you had any problems with your eyes or vision? | <input type="radio"/> | <input type="radio"/> |
| Do you wear glasses, contacts, or protective eyewear? | <input type="radio"/> | <input type="radio"/> |
| 2. Have you ever had a sprain, strain, or swelling after injury? | <input type="radio"/> | <input type="radio"/> |
| Have you broken or fractured any bones or dislocated any joints? | <input type="radio"/> | <input type="radio"/> |
| Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? | <input type="radio"/> | <input type="radio"/> |
| If yes, check appropriate box and explain below. | | |
| <input type="radio"/> Head | <input type="radio"/> Elbow | <input type="radio"/> Hip |
| <input type="radio"/> Neck | <input type="radio"/> Forearm | <input type="radio"/> Thigh |
| <input type="radio"/> Back | <input type="radio"/> Wrist | <input type="radio"/> Knee |
| <input type="radio"/> Chest | <input type="radio"/> Hand | <input type="radio"/> Shin/calf |
| <input type="radio"/> Shoulder | <input type="radio"/> Finger | <input type="radio"/> Ankle |
| <input type="radio"/> Upper arm | | <input type="radio"/> Foot |
| 3. Do you want to weigh more or less than you do now? | <input type="radio"/> | <input type="radio"/> |
| Do you lose weight regularly to meet weight requirements for your sport? | <input type="radio"/> | <input type="radio"/> |
| 4. Do you feel stressed out? | <input type="radio"/> | <input type="radio"/> |
| 5. Record the dates of your most recent immunizations (shots) for: | | |
| Tetanus _____ | Measles _____ | |
| Hepatitis B _____ | Chickenpox _____ | |

FEMALES ONLY

16. When was your first menstrual period? _____
 When was your most recent menstrual period? _____
 How much time do you usually have from the start of one period to the start of another? _____
 How many periods have you had in the last year? _____
 What was the longest time between periods in the last year? _____

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 _____

Name: _____ Date of Birth: _____
 School: _____ Gender: M F Grade: _____

IMMUNIZATIONS / HEALTH HISTORY

- Immunization record attached
 No immunizations given today
 Immunizations given since last Health Appraisal:
- Sickle Cell Screen: Positive Negative Not done Date: _____
 PPD: Positive Negative Not done Date: _____
 Elevated Lead: Yes No Not done Date: _____
 Dental Referral Yes No Not done Date: _____

Significant Medical/Surgical History: See attached _____

- Allergies: LIFE THREATENING Food: _____ Insect: _____ Other: _____
 Seasonal Medication: _____

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Date of Exam: _____

Body Mass Index: _____	Vision - without glasses/contact lenses	R	L	Referral
Weight Status Category (BMI Percentile):	Vision - with glasses/contact lenses	R	L	
<input type="checkbox"/> less than 5 th <input type="checkbox"/> 5 th through 49 th <input type="checkbox"/> 50 th through 84 th	Vision - Near Point	R	L	
<input type="checkbox"/> 85 th through 94 th <input type="checkbox"/> 95 th through 98 th <input type="checkbox"/> 99 th and higher	Hearing <input type="checkbox"/> Pass 20 db sc both ears or:	R	L	

EXAM ENTIRELY NORMAL Tanner: I. II. III. IV V Scoliosis: Negative Positive: _____

Specify any abnormality (use reverse of form if needed): _____

MEDICATIONS

Medications (list all): None Additional medications listed on reverse of form

Name: _____ Dosage/Time: _____
 Name: _____ Dosage/Time: _____

If AM dose is missed at home: _____
 I assess this student to be self-directed Yes No Student may self carry and self administer medication Yes No

Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / USE CONSIDERATION

- Physically qualified for all physical education, sports, playground, work & school activities OR only as checked:
 ___ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
 ___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.
- Specify medical accommodations needed for school: _____ None
 Known or suspected disability: _____ Please monitor
 Restrictions: _____ Please monitor
 Protective equipment required: Athletic Cup Sport goggles/impact resistant eyewear Other: _____

OPTIONAL INFORMATION (if known)

Specify current diseases: Asthma Diabetes Type-1 Type-2 Hyperlipidemia Hypertension
 Other: _____

Provider's Signature: _____ Phone: _____ (Stamp below)
 Provider's Name/Address: _____ Fax: _____
 Parent Signature: _____ Date: _____