

Pre-Participation Physical Evaluation

SCHOOL _____ DATE _____
 Name: _____ Phone: (____) _____
 Address: _____ City: _____ Zip: _____
 Sex: _____ Age: _____ Date of Birth: _____
 Grade: _____
 Personal Physician: _____ Phone: (____) _____

Previous school attended and dates: _____

Explain "Yes" answers below:

Check Yes or No

1. Have you ever been hospitalized?	Yes	No	
Have you ever had surgery?	Yes	No	
Are you presently under a doctor's care?	Yes	No	
2. Are you presently taking any medications or pills?	Yes	No	
3. Do you have any allergies (medicine, bees or other stinging insects)?	Yes	No	
4. Have you ever passed out during or after exercise?	Yes	No	
Have you ever been dizzy during or after exercise?	Yes	No	
Have you ever had chest pain during or after exercise?	Yes	No	
Have you ever had high blood pressure?	Yes	No	
Have you ever been told that you have a heart murmur?	Yes	No	
Have you ever had racing of your heart or skipped heartbeats?	Yes	No	
Has anyone in your family died of heart problems or a sudden death before age 50?	Yes	No	
Has anyone in your family had Marfan's syndrome?	Yes	No	
5. Do you have any skin problems (itching, rashes, acne)?	Yes	No	
6. Have you ever had a head injury?	Yes	No	
Have you ever been knocked out or unconscious?	Yes	No	
Have you ever had a seizure, "fit" or epilepsy?	Yes	No	
Have you ever had a stinger, burner or pinched nerve?	Yes	No	
7. Have you ever had heat cramps, heat illness or muscle cramps?	Yes	No	
8. Do you have trouble breathing or do you cough during or after activity?	Yes	No	
9. Do you use any special equipment (pads, braces, neck rolls, eye guards, etc.)?	Yes	No	
10. Have you had any problems with your eyes or vision?	Yes	No	
Do you wear glasses or contacts or protective eye wear?	Yes	No	
11. Are you missing an eye, kidney or testicle?	Yes	No	
12. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints?	Yes	No	

Head	Shoulder	Thigh	Neck	Elbow	Knee	Foot
Forearm	Shin/calf	Back	Wrist	Ankle	Hip	Hand

What was the longest time between your periods last year? _____

Explain "Yes" answers: _____

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

Date: _____

Signature of athlete: _____

Signature of parent/guardian: _____

PHYSICAL EXAMINATION

SCHOOL

NAME _____

Name: _____ **Age:** _____ **Date of Birth:** _____

Height: _____ **Weight:** _____ **BP:** _____ / _____ **Pulse:** _____

Vision: R20/ _____ **L20/** _____ **Corrected: Y N Pupils (Circle) Equal/Unequal R>L L>R**

	Circle (if option given)	-----Specific Findings-----
Marfan's syndrome stigmata	No / Yes	
Heart		
Rhythm	Regular / Irregular	
Murmur (supine)	No / Yes	
Murmur (standing)	No / Yes	
	Normal (check)	Specific Findings
Lungs		
Skin		
Abdominal		
Femoral Pulses		
Genitalia/Hernia		
Musculoskeletal		
Neck		
Shoulders		
Elbows		
Wrists		
Hands		
Back		
Knees		
Ankles		
Feet		
Other		

Clearance:

A. Cleared

B. Cleared after completing evaluation/rehabilitation for: _____

C. Not Cleared Due to: _____

Recommendation: _____

I hereby certify that this athlete was examined by me. At that time, no physical condition was detected which would reasonably be anticipated to render this athlete physically unfit to engage in any sport, except those marked below:

Boys Sports: Baseball, Basketball, Cross Country, Football, Golf, Soccer, Swimming, Tennis, Track, Wrestling*

Girls Sports: Basketball, Cross Country, Golf, Gymnastics, Soccer, Softball, Swimming, Tennis, Track, Volleyball

***Weight loss permitted to make lower weight class in Wrestling? ___ Yes ___ No; If "Yes," may lose _____ pounds.**

Name of Physician: _____ **Date:** _____

Address: _____

Phone:(_____) _____

Signature of Physician: _____

(Based on recommendations developed by the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine and American Osteopathic Academy of Sports Medicine.)