PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

(Note: The student and parent must fill out this form prior to seeing the provider. The provider should keep a copy of this form in the chart.)

NAME: _____ **Date of Birth** _____

Sex _____ **Age** _____ **Grade** _____ **School/Sport** _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal/nutritional) that you are currently taking.

Do you have any allergies? Yes_____ No_____ *If yes,* please identify specific allergy below.

Do you currently use an EpiPen? Yes_____ No_____ _____Medicines _____Pollen _____Food _____Stinging Insects

Explain "Yes" answers below. ***Please circle questions you do not know the answers to.***

GENERAL QUESTIONS	YES	NO
1 .Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medicals conditions? If so, please identify **Asthma** ☐ **Anemia** ☐ **Infections** ☐ **Diabetes** ☐		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**YES**	**NO**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High BP ☐ Heart Murmer ☐ Heart Infection ☐ High Cholesterol ☐ Kawasaki Disease		
9. Has a doctor ever ordered a test for your heart ? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**YES**	**NO**
13. Has any family member or relative died of heart problems or had an unexpected sudden death before age 50 (including drowning, unexplained car accident or sudden infant death syndrome)?		
14. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
15. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**YES**	**NO**
16. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
17. Have you ever had any broken or fractured or dislocated joints?		
18. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
19. Have you ever had a stress fracture?		
20. Do you regularly use a brace, orthotics, or other assistive device?		
21. Do you have a bone, muscle, or joint injury that bothers you?		
22. Do any of your joints become painful, swollen, feel warm, or look red?		
MEDICAL QUESTIONS	**YES**	**NO**
23. Do you cough, wheeze, or have difficulty breathing during or after exercises?		
24. Have you ever used an inhaler or taken asthma medicine?		
25. Is there anyone in your family who has asthma?		
26. Do you currently use an asthma Rescue inhaler?		

	YES	NO
27. Do you have groin pain or a painful bulge or hernia in the groin area?		
28. Do you have any rashes, pressure sores, or other skin problems?		
29. Have you ever had a head injury or concussion(s)? If yes, please provide date(s):_____,_____,_____ .		
30. Do you have a history of seizure disorder?		
31. Have you had a herpes or MRSA skin infection?		
32. Do you have headaches with exercise?		
33. Have you ever had numbness, tingling, or weakness in your arms, or legs after being hit or falling?		
34. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
35. Have you ever been unable to move your arms or legs after being hit or falling?		
36. Have you ever become ill while exercising in the heat?		
37. Do you get frequent muscle cramps when exercising?		
38. Have you had any problems with your eyes or vision?		
39. Have you had any eye injuries?		
40. Do you wear glasses or contact lenses?		
41. Do you wear protective eyewear, such as goggles or a face shield?		
42 Are you trying or has anyone recommended that you gain or lose weight?		
43. Are you on a special diet or do you avoid certain types of foods?		
44. Have you ever had an eating disorder?		
[redacted]		
45. Do you have any concerns that you would like to discuss with a doctor?		
46. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
[redacted]		
[redacted]		
FEMALES ONLY	**YES**	**NO**
47. Have you ever had a menstrual period?		
48. How old were you when you had your first menstrual period?		
49. 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. ***Revised 6/2019***

X Signature of Athlete _____ Date: _____

X Signature of Parent/Guardian _____ Date: _____

PRE-PARTICIPATION PHYSICAL EVALUATION for INTERSCHOLASTIC ATHLETICS

This page to be completed by physician/nurse practitioner/physician assistant

STUDENT NAME: _____ Date of Birth: _____

HEIGHT: _____ WEIGHT: _____ % BODY FAT (optional) _____ PULSE: _____ BP: _____

VISION: R 20/ _____ L 20/ _____ CORRECTED? Y N PUPILS: EQUAL _____ UNEQUAL _____

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

*Station-based examination only

CLEARANCE:

□ Cleared

□ Cleared after completing evaluation/rehabilitation for: _____

□ NOT cleared for [Sport(s)]: _____ Reason: _____

Recommendation: _____

Name of Physician/Nurse Practitioner/Physician's Assistant _____ Date: _____

Print or Type

Address: _____ Phone: _____

Signature of Physician/Nurse Practitioner/Physician Assistant _____

I hereby certify that I have reviewed the student pre-participation History Form and performed a comprehensive pre-participation physical evaluation of the herein named student.

***DATE OF EXAM: _____**

PHYSICIANS STAMP:

REVISED 6/2020

PRE-PARTICIPATION COVID-19
Supplemental Questions for Student's Physical

This form should be completed by the student's physician at the time of a physical.

Student History

1. Has your child or adolescent been diagnosed with COVID-19?

   Yes No

2. Was your child or adolescent hospitalized as a result for complications of COVID-19?

   Yes No

3. Has your Child been diagnosed with Multi-inflammatory Syndrome in Children?

   Yes No

4. Has your child or adolescent had direct known exposure to someone diagnosed with COVID-19?

   Yes No

Please address any "yes" answers to the above questions here:

_____

_____