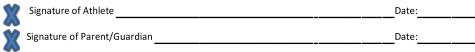
PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

(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.)

ME:		Date of Birth									
Age Grade School/Sport											
			_								
dicines and Allergies: Please list all of the prescription and o	over-the	-counte	er m	edicines and supplements (herbal/nutritional) that you are cur	rently tal	king.					
ou have any allergies? Yes No			If y	es, please identify specific allergy below.							
you currently use an EpiPen? YesNo			Med	dicinesPollenFoodStinging Insects							
olain "Yes" answers below. <i>Please circle questions you do n</i>	ot know	the ar	1SW/	ers to	YES N	JΩ					
GENERAL QUESTIONS	YES	NO	1911	27. Do you have groin pain or a painful bulge or hernia in the groin	T	Ï					
.Has a doctor ever denied or restricted your participation in sports	TES	NO		area? 28. Do you have any rashes, pressure sores, or other skin problems?	-	_					
or any reason?											
. Do you have any ongoing medicals conditions? If so, please lentify				29. Have you ever had a head injury or concussion(s)?							
Asthma Anemia				If yes, please provide date(s):,,,							
Infections Diabetes											
Have you ever spent the night in the hospital? Have you ever had surgery?	<u> </u>	_		30. Do you have a history of seizure disorder? 31. Have you had a herpes or MRSA skin infection?	-	_					
HEART HEALTH QUESTIONS ABOUT YOU	YES	NO		32. Do you have headaches with exercise?		\vdash					
. Have you ever passed out or nearly passed out DURING or FTER exercise?				33. Have you ever had numbness, tingling, or weakness in your arms, or legs after being hit or falling?							
. Have you ever had discomfort, pain, tightness, or pressure in your				34. Have you ever had a hit or blow to the head that caused							
hest during exercise? . Does your heart ever race or skip beats (irregular beats) during				confusion, prolonged headache, or memory problems? 35. Have you ever been unable to move your arms or legs after being							
xercise?				hit or falling?							
. Has a doctor ever told you that you have any heart problems? If o, check all that apply:				36. Have you ever become ill while exercising in the heat?							
				37. Do you get frequent muscle cramps when exercising?	-	_					
High BP Heart Murmer Heart Infection				38. Have you had any problems with your eyes or vision? 39. Have you had any eye injuries?		_					
High Cholesterol Kawasaki Disease				40. Do you wear glasses or contact lenses?	-						
. Has a doctor ever ordered a test for your heart ? (For example,		\vdash		41. Do you wear protective eyewear, such as goggles or a face		\vdash					
CG/EKG, echocardiogram) 0. Do you get lightheaded or feel more short of breath than	<u> </u>			shield? 42 Are you trying or has anyone recommended that you gain or lose	-						
xpected during exercise?				weight?							
Have you ever had an unexplained seizure? Do you get more tired or short of breath more quickly than your				43. Are you on a special diet or do you avoid certain types of foods?							
riends during exercise?				44. Have you ever had an eating disorder?							
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	YES	NO									
3. Has any family member or relative died of heart problems or ad an unexpected sudden death before age 50 (including drowning,				45. Do you have any concerns that you would like to discuss with a							
nexplained car accident or sudden infant death syndrome)?				doctor?							
Does anyone in your family have a heart problem, pacemaker, r implanted defibrillator?				46. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?							
5. Has anyone in your family had unexplained fainting,											
nexplained seizures, or near drowning? BONE AND JOINT QUESTIONS	YES	NO									
6. Have you ever had an injury to a bone, muscle, ligament, or	IES	NO									
endon that caused you to miss a practice or a game?											
7. Have you ever had any broken or fractured or dislocated joints? 8. Have you ever had an injury that required x-rays, MRI, CT scan,	-	-		FEMALES ONLY	YES	NO					
ajections, therapy, a brace, a cast, or crutches?				47. Have you ever had a menstrual period?							
9. Have you ever had a stress fracture? 0. Do you regularly use a brace, orthotics, or other assistive	<u> </u>	-		48. How old were you when you had your first menstrual period?	-						
evice?				49. How many periods have you had in the last 12 months?							
Do you have a bone, muscle, or joint injury that bothers you? Do any of your joints become painful, swollen, feel warm, or				Explain "yes" answers here:							
ook red?											
MEDICAL QUESTIONS	YES	NO									
3. Do you cough, wheeze, or have difficulty breathing during or fter exercises?											
4. Have you ever used an inhaler or taken asthma medicine?											
5. Is there anyone in your family who has asthma? 6. Do you currently use an asthma Rescue inhaler?	\vdash	 		1							
ereby state that, to the best of my knowledge, my answers to the a	-				2019						



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: _	% B	BODY FAT (option	al)	PULSE:	BP:_		
VISION: R 20/	L 20/	CORF	RECTED? Y	Date of Birth: al) PULSE: N PUPILS: EQUAL		UNE	UNEQUAL	
		NORMAL	ABNORMAL F	INDING			INITIALS *	
MEDICAL					18.			
Appearance								
Eyes/Ears/Nose/Throat								
Lymph nodes								
Heart								
Pulses								
Lungs								
Abdomen								
Genitalia (males only)					10.10			
Skin					10-10-			
MUSCULOSKELET	TAL .							
Neck								
Back		" "						
Shoulder/Arm								
Elbow/Forearm								
Wrist/Hand								
Hip/Thigh								
Knee								
Leg/Ankle								
Foot								
CLEARANCE: □ Cleared					*Station-based exami	nation only		
□ Cleared after cor	mpleting evalua	ation/rehabilitat	ion for:					
□ NOT cleared for [S	Sport(s)]:		Reas	son:				
Recommendatio								
Name of Physician/Nurse Practitioner/Physician's AssistantDate								
Address:			Print or TypePhone:					
Signature of	Physician/Nurs	se Practitioner/F	Physician Assistan	ıt				
I hereby certify that participation physica				istory Fo	orm and performed a	comprehe	ensive pre-	
*DATE OF EXAM: _					PHYSICIANS	STAMP:		
REVISED 6/2020								