

PHYSICAL EVALUATION

Date of Exam: _____

Name: _____ Gender: ____ Age: _____ Date of Birth: _____

Grade: _____ School: _____ Sport(s): _____

Address: _____ Phone: _____

Personal Physician: _____ Phone: _____

In Case of Emergency Contact:

Name: _____ Relationship: _____ Phone (H): _____ (W) _____
 (C) _____

Please answer all questions below. Explain any "Yes" Answer in the space provided and Circle any question you don't know the answer to.

- | | | |
|---|-----|----|
| 1. Has a doctor ever denied or restricted your participation in sports for any reason? | Yes | No |
| 2. Do you have an ongoing medical condition like diabetes, asthma, or high blood pressure? | Yes | No |
| 3. Do you have any allergies to medications, pollens, foods, or stinging insects? | Yes | No |
| 4. Have you ever passed out or nearly passed out during or after exercise? | Yes | No |
| 5. Have you ever had discomfort, pain, or pressure in your chest during exercise? | Yes | No |
| 6. Does your heart race or skip beats during exercise? | Yes | No |
| 7. Has a doctor ever ordered a test for your heart called an EKG? | Yes | No |
| 8. Has anyone in your family died of a heart problem before age 50? | Yes | No |
| 9. Does anyone in your family have Marfan's Syndrome? | Yes | No |
| 10. Have you ever spent the night in the hospital? | Yes | No |
| 11. Have you ever had surgery? | Yes | No |
| 12. Have you ever had an injury that caused you to miss a practice or game? | Yes | No |
| 13. Have you ever had a broken or dislocated bone? | Yes | No |
| 14. Do you regularly use a brace or other assistive device? | Yes | No |
| 15. Has a doctor ever told you that you have asthma or allergies? | Yes | No |
| 16. Do you cough, wheeze, or have difficulty breathing during exercise? | Yes | No |
| 17. Have you ever used an inhaler or taken asthma medicines? | Yes | No |
| 18. Were you born without or are you missing a kidney, eye, a testicle or any other organ? | Yes | No |
| 19. Have you had infectious mononucleosis (mono) in the last month? | Yes | No |
| 20. Do you have any rashes or other skin problems? | Yes | No |
| 21. Have you had a herpes skin infection? | Yes | No |
| 22. Have you ever had a concussion? | Yes | No |
| 23. Have you ever hit your head and been confused or lost your memory? | Yes | No |
| 24. Do you have headaches with exercise? | Yes | No |
| 25. Have you ever had weakness, numbness or tingling after being hit or falling? | Yes | No |
| 26. Have you ever had a seizure? | Yes | No |
| 27. When exercising in the heat, do you have muscle cramps and become ill? | Yes | No |
| 28. Has a doctor told you or anyone in your family that they have sickle cell trait or sickle cell disease? | Yes | No |
| 29. Have you had any problem with your eyes or vision? | Yes | No |

MEDICATIONS:

1. _____
2. _____
3. _____
4. _____

ALLERGIES:

1. _____
2. _____
3. _____

30. Do you wear glasses or contacts? Yes No
 31. Are you happy with your weight? Yes No

FEMALES ONLY

32. Have you ever had a menstrual period? Yes No
 33. How old were you when you had your first period? _____

Explain any "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 _____ Date: _____

Signature of Parent/Guardian _____ Date: _____

Athletic Pre-participation Physical Evaluation

Name _____ Date of Birth: _____
 Height: _____ Weight: _____ BMI: _____ Pulse: _____ BP: _____ / _____
 Vision: R 20/____, L 20/____ Corrected: Y / N Pupils: Equal _____ or Unequal _____ Allergies _____

	NORMAL	ABNORMAL	INITIALS
GENERAL			
General Appearance			
HEENT			
Hearing			
Lymph Nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
GU (males only)			
MUSCULOSKELETAL			
Neck			
Back			
Shoulders/Arms			
Elbow/Forearm			
Wrist/Hand/Fingers			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			

Pre-participation Physical Evaluation Clearance

Name of Athlete: _____

Birthdate: _____

Grade: _____

School: _____

Athlete is cleared without restrictions.

Athlete is cleared with the following restrictions:

Athlete is not cleared to participate

Name of Physician: _____ M.D. or D.O.

Address _____ Phone: _____

Signature of Physician _____ Date: _____