## **Pre-participation Physical Evaluation**

| Date of   | of Exam:                    |   |                |               |           |  |         |   |   |                                 |                                  |     |     |
|---|-----------------------------|---|----------------|---------------|-----------|--|---------|---|---|---------------------------------|----------------------------------|-----|-----|
| Name  |                             |   | Sex Age        |               |           | Date of Birth                                    |         |   |   |                                 |                                  |     |     |
| Grade School  |                             |   | •              |               |           |  |         | Sport(s)                                      |   |                                 |                                  |     |     |
| Address   |                             |   |                |               | P         |  |         |   |   |                                 |                                  |     |     |
| Perso   | nal Phys                    | ician   |                |               |           |  |         |   |   |                                 |                                  |     |     |
| In cas  | e of eme                    | rgency, co  | ntact:         |               |           |  |         |   |   |                                 |                                  |     |     |
| Relationship Ph   |                             |   |                | hone (H)      |           |  |         | Phone   | (W)   |                                 |                                  |     |     |
|   |                             | wers below.   |                |               | ı ı       |  |         | 31. H   | ave   | you ever had a head inju        | ry or concussion?                |     |     |
| Circle q  | questions yo                | ou don't knov                                       | v the answe    | r to.         |           |  |         |   |   |                                 | and been confused or lost your   |     |     |
|   |                             |   |                |               |           | Yes  | No      |   | ave   | ory?<br>you ever had a seizure? |                                  |     |     |
|   | s a doctor everts for any i | ver denied or                                       | restricted yo  | ur participa  | tion in   |  |         |   |   | ou have headaches with          | xercise?                         |     |     |
|   |                             | n ongoing me  | dical conditi  | on (like dia  | betes,    |  |         | -   | 0 ,0  | ya nave neaddenes wan           | ACTOING !                        | Yes | No  |
| astl  | hma)?                       |   |                |               |           |  |         |   |   |                                 | tingling, or weakness in your    | 105 | 110 |
|   |                             | tly taking any<br>ter) medicine                     |                | n or nonpres  | scription |  |         |   | arms or legs after being hit or falling?  |                                 |                                  |     |     |
|   |                             | llergies to me                                      |                | ens, foods, o | or        |  |         |   | 36. Have you ever been unable to move your arms or legs after<br>being hit or falling?                        |                                 |                                  |     |     |
| stin  | ging insects                | s?  |                |               |           |  |         | 37. V   | /hen  | exercising in the heat, of      | lo you have severe muscle        |     |     |
|   | ve you ever<br>rcise?       | passed out or                                       | nearly passe   | ed out DUR    | ING       |  |         |   |   | ps or become ill?               |                                  |     |     |
| 6. Ha   | ve you ever                 | passed out or                                       | nearly passe   | ed out AFT    | ER        |  |         |   | 38. Has a doctor told you that you or someone in your family has<br>sickle cell trait or sickle cell disease? |                                 |                                  |     |     |
|   | rcise?                      | . 11  | 1 . 1 .        |               |           |  |         |   |   | you had any problems w          |                                  |     |     |
|   |                             | t race or skip<br>t race or skip                    |                |               |           |  |         | 40. E   | о уо  | ou wear glasses or contac       | et lenses?                       |     |     |
| 9. Has  | s a doctor e                | ver told you th                                     |                |               | hat       |  |         |   |   |                                 | ear, such as goggles or a face   |     |     |
| app   | oly):<br>Higl               | h blood pressu                                      | ire            |               |           |  |         |   | re v  | 1?<br>ou happy with your weig   | rht?                             |     |     |
|   |                             | eart murmur   | ii c           |               |           |  |         |   | 43. Are you trying to gain or lose weight?  |                                 |                                  |     |     |
|   |                             | n cholesterol                                       |                |               |           |  |         |   |   |                                 | change your weight or eating     |     |     |
| 10. Ha  |                             | eart infection<br>wer ordered a                     | est for your   | heart? (i.e., | ECG.      |  |         | h   | habits?   |                                 |                                  |     |     |
| ech   | ocardiograi                 | n)  |                |               |           |  |         | _   |   | ou limit or carefully cont      | •                                |     |     |
|   |                             | your family d                                       |                |               | on?       |  |         |   | o yo<br>doct  |                                 | t you would like to discuss with |     |     |
|   |                             | member or r   |                |               | blems or  |  |         |   |   | S ONLY                          |                                  |     |     |
| of s  | sudden deat                 | h before age 5                                      | 0?             |               |           |  |         | 47. H   | ave   | you ever had a menstrua         | l period?                        |     |     |
| 14. Does anyone in your family have Marfan syndrome?  |                             |   |                |               |           | 48. H  | ow o    | old were you when you                         | had your first menstrual period?  |                                 |                                  |     |     |
|   | •                           | spent the nigl                                      | nt in a hospit | al?           |           |  |         | 49. H   | low i   | many periods have you l         | nad in the last 12 months?       |     |     |
|   | •                           | had surgery?  | 121            | ,             |           |  |         | Expla   | in "  | Yes" answers here:              |                                  |     |     |
| tea   | r, or tendon                | had an injury<br>itis that caused<br>fected area be | d you to mis   |               |           |  |         |   |   |                                 |                                  |     |     |
|   |                             | any broken or<br>circle below:                      | fractured bo   | ones or dislo | cated     |  |         |   |   |                                 |                                  |     |     |
|   |                             | a bone or join                                      | t injury that  | required x-1  | ays,      | <del>                                     </del> |         | ┥   |   |                                 |                                  |     |     |
| MF  | RI, CT, surg                | ery, injections                                     | , rehabilitati | ion, physica  |           |  |         |   |   |                                 |                                  |     |     |
| a bi<br>Head  | race, a cast,<br>Neck       | or crutches?<br>Shoulder                            | Upper Upper    | Elbow         | Forearm   | Hand /   | Chest   | $\dashv$ $\mid$ $\mid$                        |   |                                 |                                  |     |     |
|   | Lower                       |   | Arm            | Knee          | Calf /    | Fingers<br>Ankle                                 | Foot /  | <b>⊣                                    </b>  |   |                                 |                                  |     |     |
| Upper<br>back   | back                        | Hip   | Thigh          | vuee          | Shin      | Ankie  | toes /  | <b>」∣                                    </b> |   |                                 |                                  |     |     |
|   | -                           | had a stress f                                      |                |               |           | 1  |         | _   |   |                                 |                                  |     |     |
| 21. Have you been told that you have or have you had an x-ray<br>for atlantoaxial (neck) instability?   |                             |   |                |               |           |  |         |   | st of my knowledge, my ans  | wers to t                       | the                              |     |     |
| <ul><li>22. Do you regularly use a brace or assistive device?</li><li>23. Has a doctor ever told you that you have asthma or allergies?</li></ul> |                             |   |                |               |           | _   abov   | e qi    | uestions are comple                           | ne and confect  |                                 |                                  |     |     |
|   |                             | wheeze, or h  | •              |               |           |  |         | Sign  | atuı  | re of athlete:                  |                                  |     |     |
| afte  | er exercise?                |   |                |               | daring or |  | <u></u> | ╛   |   |                                 |                                  |     |     |
|   |                             | in your fami  | •              |               |           |  |         |   | af:::   | re of parent / mined            | ian:                             |     |     |
|   |                             | used an inhal                                       |                |               |           |  |         | _   Jign                                      | atul  | re or harent / Rusto            | 1911.                            |     |     |
| 27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?  |                             |   |                |               |           |  |         |   |   |                                 |                                  |     |     |
| 28. Have you had infectious mononucleosis (mono) within the last month?   |                             |   |                |               |           | Date   | :       |   |   |                                 |                                  |     |     |
| 29. Do you have any rashes, pressure sores, or other skin problems?   |                             |   |                |               |           |  |         |   |   |                                 |                                  |     |     |
| 30. Have you had a herpes skin infection?   |                             |   |                |               |           | 7  |         |   |   |                                 |                                  |     |     |

HISTORY FORM

## **Pre-participation Physical Evaluation**

## PHYSICAL EXAMINATION FORM

| Name                           |        |                | Date of Birth  |            |  |  |
|--------------------------------|--------|----------------|----------------|------------|--|--|
| Height                         | Weight | BP             |                |            |  |  |
| Vision: R 20 / L 20            | )/(    | Corrected: Y N | Pupils: Equal  | Unequal    |  |  |
| Medical                        | Normal | Abn            | ormal Findings | Initials   |  |  |
| Appearance                     |        |                |                |            |  |  |
| Eyes/ears/nose/throat          |        |                |                |            |  |  |
| Hearing                        |        |                |                |            |  |  |
| Lymph nodes                    |        |                |                |            |  |  |
| Heart                          |        |                |                |            |  |  |
| Murmurs                        |        |                |                |            |  |  |
| Pulses                         |        |                |                |            |  |  |
| Lungs                          |        |                |                |            |  |  |
| Abdomen                        |        |                |                |            |  |  |
| Genitourinary (males only)     |        |                |                |            |  |  |
| Skin                           |        |                |                |            |  |  |
| MUSCULOSKETAL                  |        |                |                |            |  |  |
| Neck                           |        |                |                |            |  |  |
| Back                           |        |                |                |            |  |  |
| Shoulder/arm                   |        |                |                |            |  |  |
| Elbow/forearm                  |        |                |                |            |  |  |
| Wrist/hand/fingers             |        |                |                |            |  |  |
| Hip/thigh                      |        |                |                |            |  |  |
| Knee                           |        |                |                |            |  |  |
| Leg/ankle                      |        |                |                |            |  |  |
| Foot/toes                      |        |                |                |            |  |  |
| <i>Notes:</i>                  |        |                |                |            |  |  |
|                                |        |                |                |            |  |  |
|                                |        |                |                |            |  |  |
| Name of physician (print/type) |        |                | Date           |            |  |  |
| Address                        |        |                | Phone          |            |  |  |
| Signature of Physician         |        |                |                | , MD or DO |  |  |

## **Pre-participation Physical Evaluation** CLEARANCE FORM

| Signature of Physician  |                     |                         | , M                              | D or DO |
|---|---------------------|-------------------------|----------------------------------|---------|
| Address   |                     |                         | Phone                            |         |
| Name of physician (print/type)  |                     |                         | Date                             |         |
| ☐ Up to date (see attached documentation) ☐                               | Not up to date      | Specify                 |                                  |         |
| IMMUNIZATIONS (e.g., tetanus/diphtheria; measle meningococcal; varicella) | es, mumps, rubella; | hepatitis A, B; influen | za; poliomyelitis; pneumococcal; |         |
| Other information   |                     |                         |                                  |         |
| Allergies   |                     |                         |                                  |         |
| EMERGENCY INFORMATION   |                     |                         |                                  |         |
| Recommendations:  |                     |                         |                                  |         |
| □ Not cleared for □ All sports □ Certain                                  |                     |                         |                                  |         |
| □ Not aloned for □ All anouts □ Contain                                   | anoutoi             |                         | Daggam                           |         |
|   |                     |                         |                                  |         |
| Cleared with recommendations for furth                                    | her evaluation or t | reatment for:           |                                  |         |
| ☐ Cleared without restriction.  |                     |                         |                                  |         |
|   |                     |                         |                                  |         |
| Name  | Sex                 | Age                     | Date of Birth                    |         |