Pre-Participation Sports Physical

(This page to be completed by Physician/Nurse Practitioner/Physician Assistant)

PHYSICAL EXAMINATION DATE OF EXAM ______________________

NAME ____ DATE OF BIRTH ______________________

HEIGHT ________ WEIGHT ________ % BODY FAT (optional) ________ PULSE ________ BP ________

	NORMAL	ABNORMAL FINDING
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		

CLEARANCE

___ **Cleared**

___ **Cleared** after completing evaluation/rehabilitation for: ____

____

____

___ **Not Cleared** for [Sport(s)]: ____________________________ Reason: ______________________________

Recommendation: ____

____

____

Name of Physician/Nurse Practitioner/Physician Assistant ______________________ Date: ______________

Address: ____ Phone: ______________

Signature of Physician/Nurse Practitioner/Physician Assistant ____

Pre-Participation Physical Evaluation

(This page to be completed by Student and Parent/Guardian)

Name ______________________________ Sex ____ Age ____ Grade ____ Date of Birth __________

Address ____

Personal physician ____________________________ Dr. Phone Number ______________________

In case of emergency, contact: Name ____________________________

Relationship to Child ______________ Phone (H) ________________ (C) __________________

*** ***Explain "Yes" answers below. Circle questions if you don't know the answers.***

	YES	NO
1. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?	___	___
Have you been diagnosed with asthma?	___	___
Have you been prescribed by a physician to use any asthma medication?	___	___
Do you have a current consent form to self-administer the asthma medication on file with the school?	___	___
2. Do you have any allergies (for example: medicines, foods, stinging insects, pollen)?	___	___
Do you have seasonal allergies that require medical treatment?	___	___
Do you cough, wheeze or have trouble breathing during or after activity?	___	___
Have you ever had a rash or hives develop during or after exercise?	___	___
3. Do you have an ongoing chronic or serious illness (example: diabetes, bleeding disorders, etc.)?	___	___
Do you have any known deformities (for example: curvature of the spine, heart problems, blindness in one eye)?	___	___
4. Have you ever been hospitalized overnight?	___	___
Have you ever had surgery?	___	___
Have you had a medical illness or injury since your last check up or sports physical?	___	___
5. Have you ever passed out during or after exercise?	___	___
Have you ever been dizzy during or after exercise?	___	___
Have you ever had chest pain during or after exercise?	___	___
Do you get tired more quickly than your friends do during exercise?	___	___
Have you ever had racing of your heart or skipped heartbeats?	___	___
Have you had high blood pressure or high cholesterol?	___	___
Have you ever been told you have a heart murmur?	___	___
Has any family member or relative died of heart problems or of sudden death before age 50?	___	___
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	___	___
Has a physician ever denied or restricted your participation in sports for any heart problems?	___	___
6. Have you ever become ill from exercising in the heat?	___	___
7. Have you ever had a head injury or concussion?	___	___
Have you ever been knocked out, become unconscious, or lost your memory?	___	___
Have you ever had a seizure?	___	___
Do you have frequent or severe headaches?	___	___
Have you ever had numbness or tingling in your arms, hands, legs, or feet?	___	___
Have you ever had a stinger, burner, or pinched nerve?	___	___
8. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	___	___
9. Have you had any problems with your eyes or vision?	___	___
Do you wear glasses, contacts, or protective eyewear?	___	___
10. Have you ever had a sprain, strain, or swelling after injury?	___	___
Have you broken or fractured any bone, or dislocated any joints?	___	___
Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	___	___
If yes, check appropriate box and explain below. ___ Head ___ Upper Arm ___ Hand ___ Knee ___ Back ___ Elbow ___ Finger ___ Shin/Calf ___ Chest ___ Forearm ___ Hip ___ Ankle ___ Shoulder ___ Wrist ___ Thigh ___ Foot		

11. Record the dates of your most recent immunizations (shots) for:
Tetanus______________ Measles______________ Hepatitis B______________ Chickenpox ______________

EXPLAIN "Yes" answers here: ____

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In case of emergency, I/We hereby authorize my child to be treated by an available licensed physician. It is our understanding that every effort will be made to contact us immediately in case of such emergency.

We also hereby state that, to the best of our knowledge, our answers to the above questions are complete and correct.

Signature of Parent/Guardian ______________________________ Date ______________

Signature of Athlete ______________________________ Date ______________