

ALABAMA HIGH SCHOOL ATHLETIC ASSOCIATION

Preparticipation Physical Evaluation Form  
Revised 2018

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History

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_  
 Address \_\_\_\_\_ Date of birth \_\_\_\_\_  
 School \_\_\_\_\_ Grade \_\_\_\_\_ Phone \_\_\_\_\_  
 Sport \_\_\_\_\_

| Explain "Yes" answers below:   | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 1. Has a doctor ever restricted/denied your participation in sports?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been hospitalized or spent a night in a hospital?<br>Have ever had surgery?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have any ongoing medical conditions (like Diabetes or Asthma)?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you presently taking any medications or pills (prescription or over-the-counter)?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any allergies (medicine, pollens, foods, bees or other stinging insects)?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever passed out during or after exercise?<br>Have you ever been dizzy during or after exercise?<br>Have you ever had chest pain or discomfort in your chest during or after exercise?<br>Do you tire more quickly than your friends during exercise?<br>Have you ever had high blood pressure?<br>Have you ever been told that you have a heart murmur, high cholesterol, or heart infection?<br>Have you ever had racing of your heart or skipped heartbeats?<br>Has anyone in your family died of heart problems or a sudden death before age 50?<br>Does anyone in your family have a heart condition?<br>Has a doctor ever ordered a test on your heart (EKG, echocardiogram)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have any skin problems (itching, rashes, staph, MRSA, acne)?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever had a head injury or concussion?<br>Have you ever been knocked out or unconscious?<br>Have you ever had a seizure?<br>Have you ever had a stinger, burner, pinched nerve, or loss of feeling or weakness in your arms or legs?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever had heat or muscle cramps?<br>Have you ever been dizzy or passed out in the heat?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you have trouble breathing or do you cough during or after activity?<br>Do you take any medications for asthma (for instance, inhalers)?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you had any problems with your eyes or vision?<br>Do you wear glasses or contacts or protective eye wear?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you had any other medical problems (infectious mononucleosis, diabetes, infectious diseases, etc.)?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you had a medical problem or injury since your last evaluation?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever been told you have sickle cell trait?<br>Has anyone in your family had sickle cell disease or sickle cell trait?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints?<br><input type="checkbox"/> Head <input type="checkbox"/> Back <input type="checkbox"/> Shoulder <input type="checkbox"/> Forearm <input type="checkbox"/> Hand <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Ankle<br><input type="checkbox"/> Neck <input type="checkbox"/> Chest <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Finger <input type="checkbox"/> Thigh <input type="checkbox"/> Shin <input type="checkbox"/> Foot                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. When was your first menstrual period? _____<br>When was your last menstrual period? _____<br>What was the longest time between your periods last year? _____   |                          |                          |
| Explain "Yes" answers:<br>_____<br>_____<br>_____  |                          |                          |

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.

Signature of athlete \_\_\_\_\_ Date \_\_\_\_\_

Signature of parent/guardian \_\_\_\_\_

**DUPLICATE AS NEEDED**

# Preparticipation Physical Evaluation

**Rule 1, Sec. 14** — In order for a student to be eligible for interscholastic athletics, there must be on file in the Superintendent's or Principal's office a current physician's statement certifying that the student has passed a physical exam, and that in the opinion of the examining physician (M.D. or D.O.) the student is fully able to participate in interscholastic athletics (Grade s 7-12). The AHSAA Physicians Certificate (Form 5 Rev. 2018) must be used. **A physical exam will satisfy the requirement for one calendar year through the end of the month from the date of the exam. For example, a physical given on May 5, 2018, will satisfy the requirement through May 31, 2019.**

Student's name \_\_\_\_\_

## Physical Examination

Revised 2018

|         |  |        |                   |
|---------|--|--------|-------------------|
| LIMITED | Height _____ Weight _____ BP ____ / ____ Pulse _____ |        |                   |
|         | Vision R 20 / ____ L 20 / ____ Corrected: Y N        |        |                   |
|         |  | Normal | Abnormal Findings |
|         | Cardiovascular                                       |        |                   |
|         | Pulses   |        |                   |
|         | Heart  |        |                   |
|         | Lungs  |        |                   |
|         | Skin   |        |                   |
|         | E.N.T.   |        |                   |
|         | Abdominal  |        |                   |
|         | Genitalia (males)                                    |        |                   |
|         | Musculoskeletal                                      |        |                   |
|         | Neck   |        |                   |
|         | Shoulder   |        |                   |
|         | Elbow  |        |                   |
|         | Wrist  |        |                   |
|         | Hand   |        |                   |
|         | Back   |        |                   |
|         | Knee   |        |                   |
|         | Ankle  |        |                   |
| Foot    |  |        |                   |
| Other   |  |        |                   |

Clearance:

A. Cleared

B. Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_

C. Not cleared for:  Collision  Contact  Noncontact \_\_\_\_\_ Strenuous \_\_\_\_\_ Moderately strenuous \_\_\_\_\_ Nonstrenuous

Due to: \_\_\_\_\_

Recommendation: \_\_\_\_\_

Name of physician \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_, M.D. or D.O.

(Form must be signed and dated by the attending physician.)