

Santa Ana Unified School District Pre Participation Physical Evaluation

Name: _____ DOB: _____ ID#: _____

Grade: _____ School: _____ Sport(s): _____ Academic Year: 20__-20__

Medicines and Allergies: Please list all prescription, over the counter medicines and supplements (herbal and nutritional) that you are taking:

Do you have allergies? **YES NO** If **YES** please identify specific allergies below
 Medicines: _____ Pollens: _____ Food: _____ Stinging Insects: _____

Explain **YES** answers below. Circle questions you don't know the answers to.

Please answer the following questions:	YES	NO
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any on going medical conditions? If so please identify: Asthma Anemia Diabetes Infections Other(please list):		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have a heart problem? If so circle all that apply: High blood pressure A heart murmur High Cholesterol A heart infection Kawasaki disease Other (explain)		
9. Has a doctor ever ordered a test for your heart? (for example: ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before the age of 50 (including drowning, unexplained car accident or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures or near drowning?		
17. Have you ever had an injury to a bone, muscle, ligament or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability?(Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm or look red?		
25. Do you have a history of juvenile arthritis or connective tissue disease?		

Please answer the following question:	YES	NO
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone on your family that has asthma?		
29. Were you born with or are you missing a kidney, an eye, a testicle (males), your spleen or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lens?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of food?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
Females Only		
Have you ever had a menstrual period?		
If YES		
-How old were you when you had your first period?		
-How many periods have you had in the last 12 months?		

Explain 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: _____

Santa Ana Unified School District Pre Participation Physical Evaluation

This form must be kept on file by the school. This form is valid until the end of the listed academic year.

New physicals must be submitted each academic year

Name: _____ DOB: _____ ID#: _____

Grade: _____ School: _____ Sport(s): _____ Academic Year: 20__-20__

Physical Examination (must be completed by a licensed physician, licensed osteopathic physician, licensed physician assistant or registered nurse practitioner)

Height: _____ Weight: _____
 BP: _____ Pulse: _____ Vision R 20/____ Vision L 20/____ Corrected? **YES NO**

Medical	Normal	Abnormal Findings
Appearance		
Eyes/ears/nose/throat <ul style="list-style-type: none"> • Pupils equal • Hearing 		
Lymph nodes		
Heart ¹ <ul style="list-style-type: none"> • Murmurs (auscultation standing, supine, +/-Valsalva) • Location of point of maximal impulse (PMI) 		
Pulses <ul style="list-style-type: none"> • Simultaneous femoral and radial pulses 		
Lungs		
Abdomen		
Genitourinary (males only) ²		
Skin <ul style="list-style-type: none"> • HSV, lesions suggestive of MRSA, tinea corporis 		
Neurologic ³		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional <ul style="list-style-type: none"> • Duck-walk, single leg hop 		

Cleared for all sports without restriction

Cleared for all sport without restriction with recommendations for further evaluation or treatment for: _____

Not Cleared: Pending further evaluation
 For any sports
 For certain sports _____
 Reason: _____

Recommendations _____

I have examined the above-named student and completed the pre-participation physical evaluation. The athlete does not present apparent clinical contradictions to practice and participate in the sport(s) as outlined above.

Name of examiner: _____ Date: _____
 Address: _____ Phone Number: _____
 Signature of examiner: _____

Office Stamp

¹ Consider ECG, echocardiogram and referral to cardiology for abnormal cardiac history or exam.
² Consider GU exam if in a private setting. Having a third party present is recommended
³ Consider cognitive evaluation or baseline neuropsychiatric testing if has a history of significant concussion