



2020-21 ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

(The parent or guardian should fill out this form with assistance from the student-athlete)

Exam Date: _____

Name: _____
Home Address: _____
Phone: _____
Date of Birth: _____
Age: _____
Gender: _____
Grade: _____
School: _____
Sport(s): _____
Personal Physician: _____
Hospital Preference: _____

In case of emergency contact:
Name: _____
Relationship: _____
Phone (Home): _____
Phone (Work): _____
Phone (Cell): _____

Name: _____
Relationship: _____
Phone (Home): _____
Phone (Work): _____
Phone (Cell): _____

Explain "Yes" answers on the following page.
Circle questions you don't know the answers to.

- | | Y | N |
|--|--------------------------|--------------------------|
| 1) Has a doctor ever denied or restricted your participation in sports for any reason? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Do you have an ongoing medical conditional (like diabetes or asthma)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Are you currently taking any prescription or nonprescription (over-the-counter) medicines or supplements? (Please specify): _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Do you have allergies to medicines, pollens, foods or stringing insects?
(Please specify): _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) Does your heart race or skip beats during exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6) Has a doctor ever told you that you have (check all that apply):
<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> A Heart Murmur <input type="checkbox"/> High Cholesterol <input type="checkbox"/> A Heart Infection | | |
| 7) Have you ever spent the night in a hospital? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8) Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9) Have you ever had an injury (sprain, muscle/ligament tear, tendinitis, etc.) that caused you to miss a practice or game? (If yes, check affected area in the box below in question 11) | <input type="checkbox"/> | <input type="checkbox"/> |
| 10) Have you had any broken/fractured bones or dislocated joints?
(If yes, check affected area in the box below in question 11): | <input type="checkbox"/> | <input type="checkbox"/> |
| 11) Have you had a bone/joint injury that required X-rays, MRI, CT, surgery, injections, rehabilitation physical therapy, a brace, a cast or crutches? (If yes, check affected area in the box below): | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Shoulder <input type="checkbox"/> Upper Arm <input type="checkbox"/> Elbow <input type="checkbox"/> Forearm | | |
| <input type="checkbox"/> Hand/Fingers <input type="checkbox"/> Chest <input type="checkbox"/> Upper Back <input type="checkbox"/> Lower Back <input type="checkbox"/> Hip <input type="checkbox"/> Thigh | | |
| <input type="checkbox"/> Knee <input type="checkbox"/> Calf/Shin <input type="checkbox"/> Ankle <input type="checkbox"/> Foot/Toes | | |

- | | Y | N |
|---|--------------------------|--------------------------|
| 12) Have you ever had a stress fracture? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13) Have you ever been told that you have, or have you had an X-ray for atlantoaxial (neck) instability? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14) Do you regularly use a brace or assistive device? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15) Has a doctor told you that you have asthma or allergies? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16) Do you cough, wheeze or have difficulty breathing during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17) Is there anyone in your family who has asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18) Have you ever used an inhaler or taken asthma medication? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19) Were you born without, are you missing, or do you have a nonfunctioning kidney, eye, testicle or any other organ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20) Have you had infectious mononucleosis (mono) within the last month? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21) Do you have any rashes, pressure sores or other skin problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22) Have you had a herpes skin infection? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23) Have you ever had an injury to your face, head, skull or brain (including a concussion, confusion, memory loss or headache from a hit to your head, having your "bell rung" or getting "dinged")? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24) Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 25) Have you ever had numbness, tingling or weakness in your arms or legs after being hit, falling, stingers or burners? | <input type="checkbox"/> | <input type="checkbox"/> |
| 26) While exercising in the heat, do you have severe muscle cramps or become ill? | <input type="checkbox"/> | <input type="checkbox"/> |
| 27) Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 28) Have you ever been tested for sickle cell trait? | <input type="checkbox"/> | <input type="checkbox"/> |
| 29) Have you had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 30) Do you wear glasses or contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 31) Do you wear protective eyewear, such as goggles or a face shield? | <input type="checkbox"/> | <input type="checkbox"/> |
| 32) Are you happy with your weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 33) Are you trying to gain or lose weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 34) Has anyone recommended you change your weight or eating habits? | <input type="checkbox"/> | <input type="checkbox"/> |
| 35) Do you limit or carefully control what you eat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 36) Do you have any concerns that you would like to discuss with a doctor? | <input type="checkbox"/> | <input type="checkbox"/> |

Females Only

Explain "Yes" Answers Here

	Y	N
37) Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
38) How old were you when you had your first menstrual period?	_____	
39) How many periods have you had in the last year?	_____	



2020-21 ANNUAL PREPARTICIPATION PHYSICAL EXAMINATION

The physician should fill out this form with assistance from the parent or guardian.)

Student Name: _____

Date of Birth: _____

Patient History Questions: Please Tell Me About Your Child...

	Y	N
1) Has your child fainted or passed out DURING or AFTER exercise, emotion or startle?	<input type="checkbox"/>	<input type="checkbox"/>
2) Has your child ever had extreme shortness of breath during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
3) Has your child had extreme fatigue associated with exercise (different from other children)?	<input type="checkbox"/>	<input type="checkbox"/>
4) Has your child ever had discomfort, pain or pressure in his/her chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
5) Has a doctor ever ordered a test for your child's heart?	<input type="checkbox"/>	<input type="checkbox"/>
6) Has your child ever been diagnosed with an unexplained seizure disorder?	<input type="checkbox"/>	<input type="checkbox"/>
7) Has your child ever been diagnosed with exercise-induced asthma not well controlled with medication?	<input type="checkbox"/>	<input type="checkbox"/>

Family History Questions: Please Tell Me About Any Of The Following In Your Family...

	Y	N		Y	N
8) Are there any family members who had sudden/unexpected/unexplained death before age 50? (including SIDS, car accidents, drowning or near drowning)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
9) Are there any family members who died suddenly of "heart problems" before age 50?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
10) Are there any family members who have unexplained fainting or seizures?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
11) Are there any relatives with certain conditions, such as:	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Enlarged Heart	<input type="checkbox"/>	<input type="checkbox"/>	Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT)	<input type="checkbox"/>	<input type="checkbox"/>
Hypertrophic Cardiomyopathy (HCM)	<input type="checkbox"/>	<input type="checkbox"/>	Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC)	<input type="checkbox"/>	<input type="checkbox"/>
Dilated Cardiomyopathy (DCM)	<input type="checkbox"/>	<input type="checkbox"/>	Marfan Syndrome (Aortic Rupture)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Rhythm Problems	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack, Age 50 or Younger	<input type="checkbox"/>	<input type="checkbox"/>
Long QT Syndrome (LQTS)	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker or Implanted Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>
Short QT Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Deaf at Birth	<input type="checkbox"/>	<input type="checkbox"/>
Brugada Syndrome	<input type="checkbox"/>	<input type="checkbox"/>			

Explain "Yes" Answers Here

I hereby state that, to the best of my knowledge, my answers to all of the above questions are complete and correct. Furthermore, I acknowledge and understand that my eligibility may be revoked if I have not given truthful and accurate information in response to the above questions.

Signature of Athlete _____

Signature of Parent/Guardian _____

Date _____

Signature of MD/DO/ND/NMD/NP/PA-C/CCSP _____

Date _____



2020-21 ANNUAL PREPARTICIPATION PHYSICAL EXAMINATION

Name: _____ Date of Birth: _____
 Age: _____ Sex: _____
 Height: _____ Weight: _____
 % Body Fat (optional): _____ Pulse: _____
 BP: ___ / ___ (___ / ___, ___ / ___)
 Vision: R20/___ L20/___ Corrected: Y N
 Pupils: Equal Unequal

	Normal	Abnormal Findings	Initials *
Medical			
Appearance			
Eyes/Ears/Throat/Nose			
Hearing			
Lymph Nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary &			
Skin			
Musculoskeletal			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hands/Fingers			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			

* - Multi-examiner set-up only

& - Having a third party present is recommended for the genitourinary examination

NOTES:

Cleared Without Restriction
 Cleared With Following Restriction: _____
 Not Cleared For: All Sports Certain Sports: _____ Reason: _____
 Recommendations: _____

Name of Physician (Print/Type): _____ Exam Date: _____
 Address: _____ Phone: _____
 Signature of Physician: _____, MD/DO/ND/NMD/NP/PA-C/CCSP