

Preparticipation Physical Evaluation - History Form

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of Birth: _____ Sex: _____

Date of Examination: _____ Sport(s): _____

List past and current medical conditions: _____

Have you ever had surgery? If yes, list all past surgical procedures: _____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional): _____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects): _____

General Questions	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
Heart Health Questions About You	Yes	No
4. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever ordered a test for your heart? (for example Electrocardiography (ECG) or echocardiography.		
9. Do you get lightheaded or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
Health Questions About Your Family	Yes	No
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 (including drowning or unexplained car accident)?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13. Does anyone in your family had a pacemaker or implanted Defibrillator before age 35?		
Bone and Joint Questions	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint or tendon that caused you to miss a game or practice?		
15. Do you have a bone, muscle, ligament or joint injury that bothers you?		

Medical Questions	Yes	No
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?		
20. Have you ever had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, tingling, or weakness in your arms or leg, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or someone in your family have sickle cell trait or disease?		
24. Have you ever had or do you have any problems with your eyes or vision?		
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special Diet or do you avoid certain types of foods?		
28. Have you ever had an eating disorder?		
Females Only	Yes	No
29. Have you ever had a menstrual period?		
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

Explain a "Yes" answer here: _____

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian: _____

Date _____

Preparticipation Physical Evaluation - Physical Form

Last Name _____ First Name _____ Middle Initial _____ Date of Birth _____

Examination						
Height:			Weight:			
BP:	/	(/)	Pulse:	
Vision:		R 20/	L 20/		Corrected ___ Yes ___ No	

Medical	Normal	Abnormal Findings
Appearance: Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse (MVP), and aortic insufficiency)		
Eyes / Ears / Nose / Throat - Pupils equal / Hearing		
Lymph Nodes		
Heart - Murmurs (auscultation standing, auscultation supine, and +/- Valsalva maneuver)		
Lungs		
Abdomen		
Skin - Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant Staphylococcus aureus (MRSA), or tinea corporis		
Neurologic		
Musculoskeletal:		
- Neck		
- Back		
- Shoulders/Arm		
- Elbow/Forearm		
- Wrist/Hand/Fingers		
- Hip/Thighs		
- Knees		
- Leg/Ankles		
- Foot/Toes		
- Functional: Double-leg squat test, single leg squat test, and box drop or step drop test		

Consider: electrocardiography (ECG), echocardiography, and referral to cardiologist for abnormal cardiac history or examination findings or a combination of those.

Preparticipation Physical Evaluation

- Medically eligible for all sports without restriction.
- Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of: _____
- Medically eligible for certain sports: _____
- Not medically eligible pending further evaluation.
- Not medically eligible for any sports.
- Recommendations: _____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. If conditions arise after the athlete had been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete and parents or guardians.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____ MD, DO, NP, or PA

COVID-19 Screening, Concussion Education, & Assumption of Risk

Student-Athlete COVID-19 Screening

Are you currently free from illness? ___ YES ___ NO

During your time away from Clinton High/Clinton Middle, did you experience, or are you currently experiencing any of the following:

Symptom	Yes/No	Length of Symptom	Explanation
Fever			
Body Chills			
Extreme Level of Fatigue			
Cough			
Pain/Difficulty Breathing			
Shortness of Breath			
Sore Throat			
Body/Muscle Aches			
Loss of Taste			
Loss of Smell			
Changes to Vision/Eye Discharge			

Additional screening questions:

Question	Yes/No
2-14 days prior to experiencing these symptoms, did you experience a suspected exposure to COVID-19?	
Have you had any direct contact with anyone who lives in/visited a place considered a COVID-19 hotspot?	
Have you had any direct contact with someone that has a suspected/confirmed case COVID-19?	
During your time away from CHS/CMS, did you self-quarantine due to suspected symptoms/exposure to COVID-19?	
During your time away from CHS/CMS, have you been living in/visited a COVID-19 hotspot?	
Have you been or are you currently diagnosed with COVID-19?	
Do you have medical documents to support diagnosis and treatment of COVID-19? Physician Name _____ Physician Location _____	

Parent Signature _____

Date _____

Student-Athlete Signature _____

List any states/cities/countries you have visited since March 15, 2020 and dates:

As a parent/guardian for the below named student-athlete, I give permission for his/her participation in athletic events and physical evaluation for that participant. I understand that this is simply a screening evaluation and not a substitute for regular healthcare. I also grant permission for treatment deemed necessary for a condition arising during participation of these events, including medical or surgical treatment that is recommended by a treating healthcare professional. I grant permission to healthcare providers, those under their direction, and coaches to have necessary medical information.

I know that the risk of injury and/or illness (including COVID-19, influenza, etc.) to my child/ward comes with participation in sports and during travel to and from play and practice. I have had the opportunity to understand the risk of injury during participation in sports through various media. My signature indicates that to the best of knowledge, my answers are correct and complete. I understand that the data acquired during these evaluations may be used for research purposes.

Parent Signature _____

A concussion is a brain injury that can be caused by blow to the head/body from contact with another player or hard surface, change the way your brain normally works, comes across differently in every athlete, and occur during practice/competition of ANY sport, and happen even if a person **does not** lose consciousness. Concussion signs and symptoms present differently in individuals and can include confusion, headache, dizziness, memory/balance problems, more emotional, nausea/vomiting, drowsiness, sensitivity to light/sound, etc. If you suspect your child/ward has a concussion you should: seek medical attention right away, allow them to take time necessary to get better, communicate with coaches and the athletic trainer, and follow medical instructions regarding care. By signing below, I understand my responsibility to report signs/symptoms to the appropriate personnel immediately.

Parent Signature _____