

PREPARTICIPATION PHYSICAL EVALUATION – MEDICAL HISTORY

This **MEDICAL HISTORY FORM** must be completed **annually** by parent (or guardian) and student in order for the student to participate in athletic activities. These questions are designed to determine if the student has developed any conditions, which would make it hazardous to participate in an athletic event.

Student's Name _____ Sex _____ Age _____ Date of Birth _____
 Address _____ Phone _____
 Grade _____ School _____
 Personal Physician _____ Phone _____

In case of emergency, contact:

Name _____ Relationship _____ Phone (H) _____ Phone (W) _____

Explain "Yes" answers below. Circle questions you don't know the answers to. Any "Yes" answers to questions 1, 2, 5, 6, 8, or 14 may require further evaluation.

	Yes	No		Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?	<input type="radio"/>	<input type="radio"/>	13. Have you ever had a hernia or appendicitis?	<input type="radio"/>	<input type="radio"/>
2. Have you been hospitalized overnight in the past year? Have you had surgery in the past year?	<input type="radio"/>	<input type="radio"/>	14. Have you ever had kidney, bladder, urinary, or rectal disorders?	<input type="radio"/>	<input type="radio"/>
3. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?	<input type="radio"/>	<input type="radio"/>	15. Do you use any special protective or corrective equipment of devices that aren't usually used for your sport or position (for example, knee braces, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	<input type="radio"/>	<input type="radio"/>
4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	<input type="radio"/>	<input type="radio"/>	Do you have a cochlear implant?	<input type="radio"/>	<input type="radio"/>
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 to 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 diabetes, hepatitis, or jaundice? Have you ever been told you have a heart murmur?	<input type="radio"/>	<input type="radio"/>	Do you have a shunt?	<input type="radio"/>	<input type="radio"/>
Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="radio"/>	<input type="radio"/>	16. Have you ever had a sprain, strain, or swelling after injury? Have you broken or fractured any bones or dislocated any joints? Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	<input type="radio"/>	<input type="radio"/>
Has any family member been diagnosed with enlarged heart, hypertrophic cardiomyopathy, long QT syndrome, Marfan's syndrome, or abnormal heart rhythm?	<input type="radio"/>	<input type="radio"/>	If yes, circle the appropriate area and explain below.		
Have you had a severe viral infection (for example, myocarditis, or mononucleosis) within the last month?	<input type="radio"/>	<input type="radio"/>	Head	Elbow	Hip Neck
Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="radio"/>	<input type="radio"/>	Back	Wrist	Thigh
6. Have you ever had a head injury or concussion? Have you ever been knocked out, become unconscious, or lost your memory? If yes, how many times? ____ When was the last concussion? ____ How severe was each one? (<i>Explain below</i>) 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?	<input type="radio"/>	<input type="radio"/>	Chest	Hand	Shin/Calf
7. Are you missing any paired organs?	<input type="radio"/>	<input type="radio"/>	Shoulder	Finger	Ankle
8. Are you under a doctor's care?	<input type="radio"/>	<input type="radio"/>	Upper Arm		Foot
9. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	<input type="radio"/>	<input type="radio"/>			
10. Have you ever become ill from exercising in the heat?	<input type="radio"/>	<input type="radio"/>	17. Do you want to weigh more or less than you do now? Do you lose weight regularly to meet weight requirements for your sport?	<input type="radio"/>	<input type="radio"/>
11. Have you ever gotten unexpectedly short of breath with exercise? Do you cough, wheeze, or have trouble breathing during or after activity? Do you have asthma? Do you have seasonal allergies that require medical treatment?	<input type="radio"/>	<input type="radio"/>	18. Do you feel stressed out?	<input type="radio"/>	<input type="radio"/>
12. Have you had any problems with your eyes or vision?	<input type="radio"/>	<input type="radio"/>	19. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?	<input type="radio"/>	<input type="radio"/>
			Females Only		
			20. When was your first menstrual period? _____ When was your most recent menstrual period? _____ How much time do you usually have from the start of one period to the start of another? _____ How many periods have you had in the last year? _____ What was the longest time between periods in the last year? _____		
			An individual answering "YES" to any question related to a possible cardiovascular health issue (question five above), as identified on the form, should be restricted from further participation until the individual is examined and cleared by a physician, physician assistant, chiropractor, or nurse practitioner.		
			** EXPLAIN "YES" ANSWERS IN THE BOX BELOW (attach another sheet if necessary): _____ _____ _____		

If, in the judgement of any representative of the school, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given said student by any physician, trainer, nurse or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student.

If, between this date and the beginning of athletic competition, any illness or injury should occur that may limit this student's participation, I agree to notify the school authorities of such illness or injury.

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

Student Signature: _____ Parent/Guardian Signature: _____ Date: _____

REPARTICIPATION PHYSICAL EVALUATION – PHYSICAL EXAMINATION

The following information must be filled in and signed by a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, or a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners.

Student's Name _____ Sex _____ Age _____ Date of Birth _____
 Height _____ Weight _____ % Body fat (optional) _____ Pulse _____ BP _____ / _____ (_____/_____, ____/____) Vision R 20/ ____ L 20/ ____
 Corrected: Y N Pupils: Equal _____ Unequal _____ Allergies: _____

As a minimum requirement, this **Physical Examination Form** must be completed prior to junior high and again prior to high school. It **must** be completed if there are yes answers to specific questions on the student's **MEDICAL HISTORY FORM**.

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS*
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart-Auscultation of the heart in the supine position			
Heart-Auscultation of the heart in the standing position			
Heart-Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Urinalysis			

MUSCULOSKELETAL

Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

* station-based examination only

SCOLIOSIS SCREENING

No curvature noted

Left	Right	Left	Right
	High Shoulder		Rib hump
	Shoulder blade stands out more than the other		Obvious curve of spine in lower back
	Obvious curve of the spine in area of the rib cage		Hip higher than the other side

CLEARANCE

Cleared
 Cleared after completing evaluation/rehabilitation for: _____
 Not cleared for: _____ Reason: _____
 Recommendations: _____

The following information must be filled in completely.
 Name (print/type): _____ Date of Examination: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone Number: _____ Fax Number: _____
 Signature: _____ License Number: _____

