

PHYSICAL EXAMINATION AND PARENT CONSENT FORM

This form is required to be filled out AFTER May 1st for the following school year and is valid until May 31st of the following year.

HISTORY FORM (should be filled out by the student and parent/guardian PRIOR to the physical examination)

Name	Sex	Age	Date of Birth
Student ID	Grade	School	Sports
Address			Phone
Personal Physician		Phone	Insurance Provider
In case of emergency, contact: Name			Relationship
Phone (H)	(C)	(W)	Email

MEDICINE & ALLERGIES Please list all of the prescription and over-the-counter medicines, inhalers, and supplements (herbal and nutritional) that you are currently taking: _____
_____ ☐ No Medications

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy: ☒ Medicines _____
☐ Pollens _____ ☒ Food _____ ☒ Stinging Insects _____

Explain "Yes" answers below in space given. Circle questions you don't know the answers to.

General Questions	Yes	No	Medical Questions	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?			24. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
2. Have you had a medical condition, injury, or illness since your last check up or sports physical?			25. Have you ever been tested for sickle cell? If yes, please explain findings. _____		
3. Have you ever been hospitalized overnight?			26. Do you or does someone in your family have sickle cell trait or disease?		
4. Do you have any ongoing medical conditions? If so, please Asthma? Anemia? Diabetes? Infections? Other?			27. Have you ever had a seizure or been diagnosed with a seizure disorder? If yes, what triggers your seizures? _____		
5. Have you ever had surgery?			28. Were you born without or are you missing a kidney, an eye, a testicle (males), spleen, or any other organ?		
Heart Health Questions About You	Yes	No	29. Do you currently have any skin problems (for example itching, rashes, acne, warts, fungus, blisters)?		
6. Have you ever passed out DURING or AFTER exercise?			30. Do you have frequent or severe headaches?		
7. Have you ever been dizzy DURING or AFTER exercises?			31. Have you ever had numbness, tingling, or weakness in your arms, hands, legs, or feet after being hit or falling?		
8. Have you ever had discomfort, pain, or pressure in your chest during or after exercise?			32. Have you had mononucleosis (mono) within the last month?		
9. Do you get tired more quickly than your friends during exercises?			33. Have you ever become ill or had severe muscle cramps after exercising in the heat?		
10. Have you ever had racing of your heart or skipped (irregular beats) heartbeats?					
11. Do you get lightheaded or feel more short of breath than expected during exercise?			34. Do you or have you had any problems with your eyes or vision?		
12. Have you ever been told you have a heart murmur?			35. Do you wear glasses, contacts, or protective eyewear?		
13. Has a doctor ever ordered a test on your heart (EKG/ECG, echocardiogram)?			36. Do you ever worry about your weight?		
14. Has your doctor ever told you that you have any heart problems? (Kawasaki disease, myocarditis, heart infection)			37. Do you want to weigh more or less than you do now?		
15. Have you ever been told you have high blood pressure or high cholesterol?			38. Do you lose weight regularly to meet weight requirements for your sport?		
16. Has a physician ever denied or restricted your participation in sports for any heart problems?			39. Do you have groin pain or a painful bulge or hernia in groin area?		
Heart Health Questions About Your Family	Yes	No	40. Have you had any problems with your eyes or vision?		
17. Has any family member or relative died of heart problems or of sudden death before the age of 50?			41. Do you wear glasses, contact lenses, or protective eyewear?		
18. Does anyone in your family have a heart problem?			Bone & Joint Questions	Yes	No
19. Does anyone in your family have a pacemaker or implanted defibrillator?			42. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or game?		
20. Does anyone in your family have Marfan syndrome, cardiomyopathy, or long Q-T?			43. Have you ever had any broken or fractured bones or dislocated joints?		
Concussion/Head Injury Questions	Yes	No	44. Do you regularly use braces, orthotics, or other assistive devices?		
21. Have you ever had a head injury or concussion? If yes, what was the date of the last one? _____ How many diagnosed concussions?			If you answered yes for the above questions, check appropriate box and explain below. ☐ Head ☐ Shoulder ☐ Wrist ☐ Thigh ☐ Ankle ☐ Neck ☐ Upper Arm ☐ Hand ☐ Knee ☐ Foot ☐ Back ☐ Elbow ☐ Finger ☐ Shin/calf ☐ Chest ☐ Forearm ☐ Hip		
22. Have you ever been knocked out, become unconscious, or lost your memory?			Females Only	Yes	No
23. Do you have frequent or severe headaches?			45. How old were you when you had your first menstrual period?		
			46. Do you experience any problems or changes with athletic participation?		
			47. How many periods have you had in the past 12 months?		

Explain "yes" answers here:

If, in the judgement of any representative of the school, the above student should need immediate care and treatment as a result of injury or sickness, I do hereby request, authorize and consent to such care and treatment as may be given said student by any physician, athletic 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.

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

Parent/Guardian Signature _____ Athlete Signature _____ Date _____



PREPARTICIPATION PHYSICAL EVALUATION

DATE OF EXAM _____

Examination

Name _____ Date of Birth _____

Height _____ Weight _____ ☐ Male ☐ Female

Blood Pressure _____/_____ Pulse _____ Vision: R 20/ L 20/ Corrected? ☐ Yes ☐ No

Have you had an energy drink in the past 6 hours? ☐ Yes ☐ No

1. Medical	Normal	Explanation of Abnormal Findings
a.) Appearance		
b.) Eyes/Ears/Nose/Throat		
c.) Lymph Nodes		
d.) Heart		
e.) Pulses		
f.) Lungs		
g.) Abdomen		
h.) Genitourinary (males only)		
i.) Skin		
j.) Neurologic		
2. Musculoskeletal	Normal	Explanation of Abnormal Findings
a.) Neck		
b.) Back		
c.) Shoulder/Arm		
d.) Elbow/Forearm		
e.) Wrist/Hand/Fingers		
f.) Hip/Thigh		
g.) Knee		
h.) Leg/Ankle		
i.) Foot/Toes		
j.) Functional		

Medical Practitioner to School Staff (please indicate any instructions or recommendations here)

Emergency Medications Required On-Site ☐ Inhaler ☐ Epinephrine ☐ Glucagon ☐ Other: _____

Comments:

☐ Cleared for all sports without restriction.

☐ Cleared for all sports without restriction **with recommendations for further evaluation for treatment for:**

☐ Not cleared
☐ Pending further evaluation ☐ For any sports ☐ For certain sports (please list):
Reason:

Recommendations:

Name & Title of Examiner (Print/Type) _____ Date _____

Address _____ Phone _____

Signature of Examiner _____