

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			Heart Health Questions About You		
6. Have you ever passed out DURING or AFTER exercise?			29. Do you currently have any skin problems (for example itching, rashes, acne, warts, fungus, blisters)?		
7. Have you ever been dizzy DURING or AFTER exercises?			30. Do you have frequent or severe headaches?		
8. Have you ever had discomfort, pain, or pressure in your chest during or after exercise?			31. Have you ever had numbness, tingling, or weakness in your arms, hands, legs, or feet after being hit or falling?		
9. Do you get tired more quickly than your friends during exercises?			32. Have you had mononucleosis (mono) within the last month?		
10. Have you ever had racing of your heart or skipped (irregular beats) heartbeats?			33. Have you ever become ill or had severe muscle cramps after exercising in the heat?		
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			Bone & Joint Questions		
17. Has any family member or relative died of heart problems or of sudden death before the age of 50?			42. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or game?		
18. Does anyone in your family have a heart problem?			43. Have you ever had any broken or fractured bones or dislocated joints?		
19. Does anyone in your family have a pacemaker or implanted defibrillator?			44. Do you regularly use braces, orthotics, or other assistive devices?		
20. Does anyone in your family have Marfan syndrome, cardiomyopathy, or long Q-T?			If you answered yes for the above questions, check appropriate box and explain below.		
Concussion/Head Injury Questions			<input type="checkbox"/> Head <input type="checkbox"/> Shoulder <input type="checkbox"/> Wrist <input type="checkbox"/> Thigh <input type="checkbox"/> Ankle <input type="checkbox"/> Neck <input type="checkbox"/> Upper Arm <input type="checkbox"/> Hand <input type="checkbox"/> Knee <input type="checkbox"/> Foot <input type="checkbox"/> Back <input type="checkbox"/> Elbow <input type="checkbox"/> Finger <input type="checkbox"/> Shin/calf <input type="checkbox"/> Chest <input type="checkbox"/> Forearm <input type="checkbox"/> Hip		
21. Have you ever had a head injury or concussion? If yes, what was the date of the last one? _____ How many diagnosed concussions?			Females Only		
22. Have you ever been knocked out, become unconscious, or lost your memory?			45. How old were you when you had your first menstrual period?		
23. Do you have frequent or severe headaches?			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 _____