

HISTORY

PREPARTICIPATION PHYSICAL EVALUATION

DATE OF EXAM

Name _____ Sex _____ Age _____ Date of Birth _____
 Grade _____ School _____ Sport(s) _____ Phone _____

Address _____

Personal Physician _____ IN CASE OF EMERGENCY, CONTACT

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

I II III A B C 1 2 3 a b c + - Social Security #: _____ - _____ - _____

PPE Inj Act FT PE

FILL YES / NO BOXES

Explain "Yes" answers below.

Circle questions you don't know the answers to completely.

- | | | |
|--|--------------------------|--------------------------|
| | Yes | No |
| 1. Have you had a medical illness or injury since your last check up or sports physical? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have an ongoing or chronic illness? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been hospitalized overnight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a rash or hives develop during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever passed out during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been dizzy during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had chest pain, chest discomfort, or unexplained shortness of breath during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you get tired more quickly than your friends do during exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had racing of your heart or skipped heartbeats? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had high blood pressure or high cholesterol? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been told you have a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has any family member or relative died of heart problems or sudden death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has any relative younger than 50 ever had disability from heart or cardiovascular disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have, or do you know any family member or relative with ANY heart condition (Marfans, cardiomyopathy, or arrhythmia - irregular heartbeat)? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has a physician ever denied or restricted your participation in sports for any heart problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had a head injury or concussion? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been knocked out, become unconscious, or lost your memory? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have frequent or severe headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had numbness or tingling in your arms, hands, legs, or feet? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a stinger, burner, or pinched nerve? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever become ill from exercising in the heat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you cough, wheeze, or have trouble breathing during or after activity? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have seasonal allergies that require medical treatment? | <input type="checkbox"/> | <input type="checkbox"/> |

- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| 10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you wear glasses, contacts, or protective eyewear? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever had a sprain, strain, or swelling after injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you broken or fractured any bones or dislocated any joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? | <input type="checkbox"/> | <input type="checkbox"/> |

ANSWER BELOW	For Examiner Use Only							
	O	S	S	C	C	D	L	F
Please MARK & FILL appropriate box of problem areas. Explain below in the space provided what you understood your injury to be. Do not mark spaces to right of this section.	v	t	p	o	o	i	a	x
	r	a	a	r	n	n	s	c
	u	i	i	u	u	o	r	e
	s	n	n	s	s	c	a	t
	e			i	s	a	t	i
				o	n	e	o	n
<input type="checkbox"/> Head								
<input type="checkbox"/> Neck								
<input type="checkbox"/> Back								
<input type="checkbox"/> Shoulder/Arm								
<input type="checkbox"/> Elbow/Forearm								
<input type="checkbox"/> Wrist/Hand/Finger								
<input type="checkbox"/> Hip/Thigh								
<input type="checkbox"/> Knee								
<input type="checkbox"/> Leg/Ankle								
<input type="checkbox"/> Foot/Toe								

13. Do you want to weigh more or less than you do now? Yes No
 Do you lose weight regularly to meet weight requirements for your sport? Yes No
14. Do you feel stressed out? Yes No
15. Record the dates of your most recent immunizations (shots) for:
 Tetanus _____ Measles _____
 Hepatitis B _____ Chickenpox _____
- FEMALES ONLY**
16. 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? _____
- Explain any INJURY here:** _____

Explain any "Yes" answers here: _____

PARENTS' PERMISSION FOR SON OR DAUGHTER TO PARTICIPATE IN ATHLETICS

TO: Principal or Superintendent:

As the parents or legal guardian of _____, I give my consent for his/her practice and play in the athletic events listed below and for the physical exam evaluation for that participation. I grant permission to nurses, trainers and coaches as well as physicians or those under their direction who are part of athletic injury prevention and treatment, to have access to necessary medical information. I grant permission for treatment deemed necessary for a condition arising during participation in these activities, including medical or emergency treatment recommended by a medical doctor. I understand that every effort will be made to contact me prior to treatment. I certify that the medical history on the preceding page is accurate to the best of my knowledge. I understand that the data acquired may be used for research purposes to improve athletic care. I give the South Carolina High School League permission to examine the school records of the above student in order to verify eligibility.

DATE _____

SIGNED _____
(Father, mother, or Legal guardian)

PREPARTICIPATION PHYSICAL EXAM

VITAL SIGNS

R L

HT _____ WT _____
VISION R 20/ L 20/
(CORRECTED)
R 20/ L 20/
CK NEG RECORD ABNORMALS

(SKINFOLD mm) _____
DENTAL _____
CK NEG RECORD ABNORMALS

PULSES: WRIST _____
FEM _____
HEART RATE _____
BP _____
CK NEG RECORD ABNORMALS

PHYSICAL

DEFORMITY _____

APPEARANCE _____

PUPILS _____

EENT _____

LUNG _____

HEART _____

ABDOMEN _____

GU _____

SKIN _____

LYMPH NODES _____

NOTES: _____

MUSCLSKEL

ROM INSTABIL _____

C SPINE _____

T SPINE _____

LS SPINE _____

SHOULDER _____

ELBOW _____

WRIST _____

HAND _____

HIP _____

KNEE _____

ANKLE _____

FOOT _____

CLEARED (I) _____ CROSS OUT SPORT NOT PERMITTED
FOOTBALL BASKETBALL BASEBALL SOFTBALL VOLLEYBALL WRESTLING FIELD HOCKEY
SOCCER CROSS COUNTRY TRACK TENNIS GOLF BOWLING CHEERLEADING SWIMMING

NEEDS FURTHER EVAL (II) _____ EVALUATION BY _____
REHAB BY _____

SECONDARY CLEARANCE (I) _____ MD or DO Date _____

NOT CLEARED(III) _____ REASON:
COLLISION _____ CONTACT _____ NONCONTACT _____
STRENUOUS _____ MODERATELY STRENUOUS _____ NONSTRENUOUS _____

NAME OF PHYSICIAN OR FACILITY:

ADDRESS:

PHONE:

SIGNATURE _____ MD or DO _____ Date _____