ANNUAL PREPARTICIPATION PHYSICAL EXAMINATION

ANNUAL PHYSICAL EXAMINATION

Name: ____ Date: _________________________

Height: __________ Weight: ___________ Pulse: ____________ BP: _____________

Vision: R 20/______ L 20/______ Glasses/Contacts: Yes ☐ No ☐ Pupils: Equal ☐ Unequal ☐

	Normal	Abnormal Findings	Initials*
Medical			
Appearance	☐		
Skin	☐		
Eyes/Ears/Nose	☐		
Throat/Oropharynx	☐		
Lymph Nodes	☐		
Heart	☐		
Pulses	☐		
Abdomen	☐		
Genitalia/Hernia	☐		
Musculoskeletal			
Neck	☐		
Back	☐		
Shoulder/arm	☐		
Elbow/forearm	☐		
Wrist/hand	☐		
Hip/thigh	☐		
Knee	☐		
Leg/ankle	☐		
Foot	☐		

*** Station-based examination only**

Clearance

☐ Cleared

☐ Cleared after completing evaluation/rehabilitation for:____

____

☐ Not cleared for: ______________________________ Reason:_________________________________

Recommendations:____

____

Names of Physician (print/type) _______________________________________ Date _________________

Address ____ Phone __________________

Signature of Physician ____ MD/DO/NP/PA-C

ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

Name ________________________ Sex ______ Age _____ Date of Birth ___________ Grade ___________________

Address ____ Phone ______________________________________

In case of emergency, contact: Name:____

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

Phone (H): ____________________ Work (H): _____________________

Cell Phone:____

	Yes	No
1. Have you had a medical illness or injury since your last check-up or sports physical?	__	__
Do you have an ongoing or chronic illness?	__	__
Are you currently being treated for an injury or condition?	__	__
2. Have you ever been hospitalized overnight?	__	__
Have you ever had surgery?	__	__
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications?	__	__
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	__	__
4. Do you have any allergies to medications?	__	__
Do you have any allergies to pollen, food or stinging insects? ________________________________	__	__
Have you ever had a rash or hives develop during or after exercise?	__	__
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 during exercise?	__	__
Have you ever had racing of our heart or skipped heartbeats?	__	__
Have you had high blood pressure or high cholesterol?	__	__
Have you ever been told you have a heart murmur?	__	__
Have you had a severe viral infection (i.e., mononucleosis or myocarditis) within the last month?	__	__
Has a doctor ever denied or restricted your participation in sports for any heart problems?	__	__
Has anyone in your immediate family had the following conditions: Diabetes ___ Heart disease ___ Other ___ Sudden death prior to age 50 ___ High Blood Pressure ___	__	__
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	__	__
7. Have you ever had a head injury or concussion?	__	__
Have you ever become knocked out, become unconscious, or lost your memory?	__	__
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?	__	__
8. Have you ever become ill from exercising in the heat?	__	__

	Yes	No
9. Do you cough, wheeze, or have trouble breathing during or after activity?	__	__
Do you have asthma?	__	__
Do you use an inhaler?	__	__
Do you have seasonal allergies that require medical treatment? ________________________________	__	__
10. Do you use any 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)? ______________________________	__	__
11. Have you ever had any problems with your eyes or vision?	__	__
Do you wear glasses, contacts, or protective eyewear? ________________________________	__	__
12. 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 problems with pain or swelling in muscles, tendons, bones, or joints?	__	__

If yes, check appropriate box below

___ Head	____ Elbow	_____ Hip
___ Neck	____ Forearm	_____ Thigh
___ Back	____ Wrist	_____ Knee
___ Chest	____ Hand	_____ Shin/calf
___ Shoulder	____ Finger	_____ Ankle
___ Upper arm		_____ Foot

____

	Yes	No
13. Do you want to weigh more or less than you do now?	__	__
Do you lose weight regularly to meet weight requirements for your sport?	__	__
14. Do you feel stressed?	__	__
15. Do you or have you ever used: Smokeless tobacco _______ Cigarettes ________ Alcohol _______ Recreational drugs ________	__	__

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 last year? _________

Explanation: ____
____
____

I hereby state that to the best of my knowledge, my answers to the above questions are complete and correct.
I understand and acknowledge that truthful and accurate information is essential in properly determining whether the student should be cleared for athletic participation.
I hereby consent for the student named above, to be given medical care by the doctor selected by the school.

______________________________ ______________________________ ______________________
Signature of Parent/Guardian Signature of Student Athlete Date

UPDATED 07/15