

# Pre-participation Physical Evaluation

Date of Exam \_\_\_\_\_

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_  
 Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_  
 Personal Physician \_\_\_\_\_  
**Insurance Company:** \_\_\_\_\_ **Policy Number:** \_\_\_\_\_  
 \*Please check with your insurance agent to be sure your plan includes tackle football if your child intends to participate in that sport.  
**In case of emergency, contact:** Name \_\_\_\_\_ Relationship \_\_\_\_\_  
 Phone (cell) \_\_\_\_\_ Phone (h) \_\_\_\_\_ Phone (w) \_\_\_\_\_

**Explain "Yes" answers below.**  
**Circle questions you do not know the answers to.**

- |   | Yes                      | No                       |  | Yes                      | No                       |              |           |  |   |                          |                          |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|--------------|-----------|--|---|--------------------------|--------------------------|
| 1. Has a doctor ever denied or restricted your participation in sports for any reason?  | <input type="checkbox"/> | <input type="checkbox"/> | 24. Do you cough, wheeze, or have difficulty breathing during or after exercise?                           | <input type="checkbox"/> | <input type="checkbox"/> |              |           |  |   |                          |                          |
| 2. Do you have an ongoing medical condition (like diabetes or asthma)?  | <input type="checkbox"/> | <input type="checkbox"/> | 25. Is there anyone in your family who has asthma?   | <input type="checkbox"/> | <input type="checkbox"/> |              |           |  |   |                          |                          |
| 3. Are you currently taking any prescription or non-prescription (over-the-counter) medicines or pills?   | <input type="checkbox"/> | <input type="checkbox"/> | 26. Have you ever used an inhaler or taken asthma medicine?  | <input type="checkbox"/> | <input type="checkbox"/> |              |           |  |   |                          |                          |
| 4. Do you have allergies to medicines, pollens, foods, or stinging insects?   | <input type="checkbox"/> | <input type="checkbox"/> | 27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?             | <input type="checkbox"/> | <input type="checkbox"/> |              |           |  |   |                          |                          |
| 5. Have you ever passed out or nearly passed out DURING exercise?   | <input type="checkbox"/> | <input type="checkbox"/> | 28. Have you had infectious mononucleosis (mono) within the last month?                                    | <input type="checkbox"/> | <input type="checkbox"/> |              |           |  |   |                          |                          |
| 6. Have you ever passed out or nearly passed out AFTER exercise?  | <input type="checkbox"/> | <input type="checkbox"/> | 29. Do you have any rashes, pressure sores, or other skin problems?  | <input type="checkbox"/> | <input type="checkbox"/> |              |           |  |   |                          |                          |
| 7. Have you ever had discomfort, pain, or pressure in your chest during exercise?   | <input type="checkbox"/> | <input type="checkbox"/> | 30. Have you had a herpes skin infection?  | <input type="checkbox"/> | <input type="checkbox"/> |              |           |  |   |                          |                          |
| 8. Does your heart race or skip beats during exercise?  | <input type="checkbox"/> | <input type="checkbox"/> | 31. Have you ever had a head injury or concussion?   | <input type="checkbox"/> | <input type="checkbox"/> |              |           |  |   |                          |                          |
| 9. Has a doctor ever told you that you have (check all that apply):   |                          |                          | 32. Have you been hit in the head and been confused or lost your memory?                                   | <input type="checkbox"/> | <input type="checkbox"/> |              |           |  |   |                          |                          |
| <input type="checkbox"/> High blood pressure  |                          |                          | 33. Have you ever had a seizure?   | <input type="checkbox"/> | <input type="checkbox"/> |              |           |  |   |                          |                          |
| <input type="checkbox"/> A heart murmur   |                          |                          | 34. Do you have headaches with exercise?   | <input type="checkbox"/> | <input type="checkbox"/> |              |           |  |   |                          |                          |
| <input type="checkbox"/> High cholesterol   |                          |                          | 35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?     | <input type="checkbox"/> | <input type="checkbox"/> |              |           |  |   |                          |                          |
| <input type="checkbox"/> A heart infection  |                          |                          | 36. Have you ever been unable to move your arms or legs after being hit or falling?                        | <input type="checkbox"/> | <input type="checkbox"/> |              |           |  |   |                          |                          |
| 10. Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram)   | <input type="checkbox"/> | <input type="checkbox"/> | 37. When exercising in the heat, do you have severe muscle cramps or become ill?                           | <input type="checkbox"/> | <input type="checkbox"/> |              |           |  |   |                          |                          |
| 11. Has anyone in your family died for no apparent reason?  | <input type="checkbox"/> | <input type="checkbox"/> | 38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? | <input type="checkbox"/> | <input type="checkbox"/> |              |           |  |   |                          |                          |
| 12. Does anyone in your family have a heart problem?  | <input type="checkbox"/> | <input type="checkbox"/> | 39. Have you had any problems with your eyes or vision?  | <input type="checkbox"/> | <input type="checkbox"/> |              |           |  |   |                          |                          |
| 13. Has any family member or relative died of heart problems or of sudden death before age 50?  | <input type="checkbox"/> | <input type="checkbox"/> | 40. Do you wear glasses or contact lenses?   | <input type="checkbox"/> | <input type="checkbox"/> |              |           |  |   |                          |                          |
| 14. Does anyone in your family have Marfan syndrome?  | <input type="checkbox"/> | <input type="checkbox"/> | 41. Do you wear protective eyewear, such as goggles or a face shield?                                      | <input type="checkbox"/> | <input type="checkbox"/> |              |           |  |   |                          |                          |
| 15. Have you ever spent the night in a hospital?  | <input type="checkbox"/> | <input type="checkbox"/> | 42. Are you happy with your weight?  | <input type="checkbox"/> | <input type="checkbox"/> |              |           |  |   |                          |                          |
| 16. Have you ever had surgery?  | <input type="checkbox"/> | <input type="checkbox"/> | 43. Are you trying to gain or lose weight?   | <input type="checkbox"/> | <input type="checkbox"/> |              |           |  |   |                          |                          |
| 17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis, that caused you to miss a practice or game? If yes, circle affected area below:           | <input type="checkbox"/> | <input type="checkbox"/> | 44. Has anyone recommended you change your weight or eating habits?  | <input type="checkbox"/> | <input type="checkbox"/> |              |           |  |   |                          |                          |
| 18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:  | <input type="checkbox"/> | <input type="checkbox"/> | 45. Do you limit or carefully control what you eat?  | <input type="checkbox"/> | <input type="checkbox"/> |              |           |  |   |                          |                          |
| 19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below: | <input type="checkbox"/> | <input type="checkbox"/> | 46. Do you have any concerns that you would like to discuss with a doctor?                                 | <input type="checkbox"/> | <input type="checkbox"/> |              |           |  |   |                          |                          |
| Head  | Neck                     | Shoulder                 | Upper Arm  | Elbow                    | Forearm                  | Hand/Fingers | Chest     | <b>FEMALES ONLY</b>  | 47. Have you ever had a menstrual period? | <input type="checkbox"/> | <input type="checkbox"/> |
| Upper Back  | Lower Back               | Hip                      | Thigh  | Knee                     | Calf/Shin                | Ankle        | Foot/Toes | 48. How old were you when you had your first menstrual period? _____ |   |                          |                          |
| 20. Have you ever had a stress fracture?  | <input type="checkbox"/> | <input type="checkbox"/> | 49. How many periods have you had in the last 12 months? _____   |                          |                          |              |           |  |   |                          |                          |
| 21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?  | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |              |           |  |   |                          |                          |
| 22. Do you regularly use a brace or assistive device?   | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |              |           |  |   |                          |                          |
| 23. Has a doctor ever told you that you have asthma or allergies?   | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |              |           |  |   |                          |                          |

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

**Signature of Athlete** \_\_\_\_\_

**Signature of Parent/Guardian** \_\_\_\_\_

Date \_\_\_\_\_

# Pre-participation Physical Evaluation

## PHYSICAL EXAMINATION FORM

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ %Body Fat (optional) \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_ (\_\_\_\_ / \_\_\_\_\_, \_\_\_\_ / \_\_\_\_\_)

Vision R 20/ \_\_\_\_\_ L20/ \_\_\_\_\_ Corrected: Y N Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

STUDENT NAME:

ID#

DATE

GR

	NORMAL	ABNORMAL FINDINGS	INITIALS*
<b>MEDICAL</b>			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Skin			
Other			
<b>MUSCULOSKELETAL</b>			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

\*Multiple-examiner set-up only.

+Having a third party present is recommended for the genitourinary examination.

Notes: \_\_\_\_\_  
 \_\_\_\_\_

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD or DO