

Pre-participation Physical Evaluation (Part I)
(to be filled out by parent/guardian)

Student's name: _____ Sex _____ Grade _____ Date of Birth _____

Address: _____ Phone _____

City _____ Sport activities: _____

Explain "yes" answers in the space below.

- | | | |
|--|---------|--------|
| 1. Has your child ever been hospitalized? | Yes ___ | No ___ |
| 2. Has your child ever had surgery? | Yes ___ | No ___ |
| 3. Is your child presently taking any medications? | Yes ___ | No ___ |
| 4. Does your child have any allergies (bee stings, insect bites, medicines)? | Yes ___ | No ___ |
| 5. Has your child ever passed out during or after exercise? | Yes ___ | No ___ |
| 6. Has your child ever been dizzy during or after exercise? | Yes ___ | No ___ |
| 7. Has your child ever had chest pain during or after exercise? | Yes ___ | No ___ |
| 8. Does your child tire more quickly than your child's friends during exercise? | Yes ___ | No ___ |
| 9. Has your child ever had high blood pressure? | Yes ___ | No ___ |
| 10. Has your child ever been told your child have a heart murmur? | Yes ___ | No ___ |
| 11. Has your child ever had racing of your child's heart or skipped heartbeats? | Yes ___ | No ___ |
| 12. Has anyone in your child's family died of heart problems or a sudden death before age of 50? Yes ___ | No ___ | |
| 13. Does your child have any skin problems (itching, rashes, or acne)? | Yes ___ | No ___ |
| 14. Has your child ever had a head injury? | Yes ___ | No ___ |
| 15. Has your child ever been knocked out or unconscious? | Yes ___ | No ___ |
| 16. Has your child ever had a seizure? | Yes ___ | No ___ |
| 17. Has your child ever had a stinger, burner, or pinched nerve? | Yes ___ | No ___ |
| 18. Has your child ever had heat or muscle cramp? | Yes ___ | No ___ |
| 19. Has your child ever been dizzy or passed out in the heat? | Yes ___ | No ___ |
| 20. Does your child have trouble breathing or do your child cough during or after activity? Yes ___ | No ___ | |
| 21. Does your child use any special equipment (pads, braces, neck rolls, mouth or eye guard, etc.)? Yes ___ | No ___ | |
| 22. Does your child have any problems with your child's eyes or vision? | Yes ___ | No ___ |
| 23. Does your child wear glasses or contacts or protective eyewear? | Yes ___ | No ___ |
| 24. Has your child had any other serious medical problems (infectious mononucleosis, diabetes, etc.)? Yes ___ | No ___ | |
| 25. Has your child had a medical problem or injury since your child's last evaluation? Yes ___ | No ___ | |
| 26. Has your child ever sprained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints? Yes ___ | No ___ | |
| 27. For girls: When was your child's first menstrual period? _____ Last? _____ | | |
| What was the longest time between your child's periods in the past year? _____ | | |

Explain "yes" answers here _____

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

Parent/guardian name (please print): _____ Date _____

Signature: _____

Pre-participation Physical Evaluation (Part II)

Student's name: _____

Date _____

List of sports to participate in: _____

Physical Examination (to be filled out by physician):

Height _____ Weight _____ BP _____ Pulse _____

	Normal	Abnormal findings
Cardiovascular		
Pulses		
Heart		
Lungs		
Skin		
ENT		
Abdomin		
Genitalia (males)		
Musculoskeletal		
Neck		
Shoulder		
Elbow		
Wrist		
Hand		
Back		
Knee		
Ankle		
Foot		
Other		

Clearance (circle one):

A. Clear for all listed sports

B. Cleared for a single sport (list sport) _____

C. Cleared after completing evaluation / rehabilitation for: _____

D. Not cleared for:

___ collision sports

___ contact sports

___ noncontact ___ strenuous ___ moderately strenuous ___ non strenuous ___

Due to: _____

Recommendation: _____

Name of physician _____ Date: _____

Signature _____, M.D. or D. O.