# PREPARTICIPATION HISTORY AND PHYSICAL EXAMINATION

(The Sport Physical is valid for 2 years from date of examination, but the expiration date **MUST COVER the ENTIRE sport season** the athlete wishes to participate in to be valid)

Student Name: _____ 2012-2013 Grade: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Sport: _____ Exam Date: _____

Parent/Guardian Name: _____

Insurance Company: _____ Insurance Plan Number: _____

Do you give your permission for a physician to administer treatment to your child and to inform school officials of the health of the student as he/she participates in athletics? Yes ☐ No ☐ (It is the parent/guardian's responsibility to notify the school any time a medical problem occurs that would affect the health of the student as he/she participates in athletics.

Student Birth Date: _____ Student Signature: _____

Parent/Guardian Signature: _____ Date: _____

## HISTORY

| | Yes | No | |
|---|---|---|---|
| 1a. | ☐ | ☐ | Have you had any illness/injury recently, or do you have an illness/injury now? |
| b. | ☐ | ☐ | Have you had a medical problem, illness or injury since your last exam? |
| c. | ☐ | ☐ | Do you have any chronic or recurrent illness? |
| d. | ☐ | ☐ | Have you ever had any illness lasting more than a week? |
| e. | ☐ | ☐ | Have you ever been hospitalized overnight? |
| f. | ☐ | ☐ | Have you had any surgery other than tonsillectomy? |
| g. | ☐ | ☐ | Have you ever had any injuries requiring treatment by a physician? |
| h. | ☐ | ☐ | Do you have any organ missing other than tonsils ( appendix, eye, kidney, testicle, etc.)? |
| 2. | ☐ | ☐ | Are you presently taking ANY medications ( including birth control pill, vitamin, aspirin, etc.)? |
| 3. | ☐ | ☐ | Do you have ANY allergies (medicines, bees, foods, or other factors)? |
| 4a. | ☐ | ☐ | Have you ever had chest pain, dizziness, fainting, passing out during or after exercise? |
| b. | ☐ | ☐ | Do you tire more easily or quickly than your friends during exercise? |
| c. | ☐ | ☐ | Have you ever had any problem with your blood pressure or your heart? |
| d. | ☐ | ☐ | Have any close relatives had heart problems, heart attack or sudden death before they were age 50? |
| 5. | ☐ | ☐ | Do you have any skin problems (acne, itching, rashes, etc.)? |
| 6a. | ☐ | ☐ | Have you ever had fainting, convulsions, seizures or severe dizziness? |
| b. | ☐ | ☐ | Do you have frequent severe headaches? |
| c. | ☐ | ☐ | Have you ever had a "stinger" or "burner" or "pinched nerve"? |
| d. | ☐ | ☐ | Have you ever been "knocked out" or "passed out"? |
| e. | ☐ | ☐ | Have you ever had a neck or head injury? |
| 7a. | ☐ | ☐ | Have you ever had heat exhaustion, heat stroke, heat cramps or similar heat-related problems? |
| 8. | ☐ | ☐ | Have you had asthma, or trouble breathing, or cough during or after exercise? |
| 9a. | ☐ | ☐ | Do you wear eyeglasses, contact lenses or protective eye wear? |
| b. | ☐ | ☐ | Have you had any problem with your eyes or vision? |
| 10. | ☐ | ☐ | Do you wear any dental appliance such as braces, bridge, plate, retainer? |
| 11a. | ☐ | ☐ | Have you ever had a knee injury? |
| b. | ☐ | ☐ | Have you ever had an ankle injury? |
| c. | ☐ | ☐ | Have you ever injured any other joint (shoulder, wrist, fingers, etc.)? |
| d. | ☐ | ☐ | Have you ever had a broken bone (fracture)? |
| e. | ☐ | ☐ | Have you ever had a cast, splint, or had to use crutches? |
| f. | ☐ | ☐ | Must you use special equipment for competition (pads, braces, neck roll, etc.)? |
| 12. | ☐ | ☐ | Has it been more than 5 years since your last tetanus booster shot? |
| 13. | ☐ | ☐ | Are you worried about your weight? |
| 14. | ☐ | ☐ | FEMALES: Have you any menstrual problems? |
| 15. | ☐ | ☐ | Have you any medical concerns about participating in your sport? |

******* ATHLETE SHOULD NOT WRITE BELOW THIS LINE *******

# PHYSICAL EXAMINATION

**(MUST BE COMPLETELY FILLED OUT – PHYSICIAN NAME MUST BE LEGIBLE)**

**Student Name:**_____ **Grade:**_____

**PHYSICIAN'S COMMENTS ON ALL "YES" ANSWERS** (REVERSE SIDE- refer to question number):

_____

_____

Age:_____ Pulse:_____

Height:_____ Blood Pressure:_____

Weight:_____

Visual Acuity: Left 20/_____ Right 20/ _____

Optional

Urinalysis:_____

Body Fat %: _____

HCT:_____

EST VO2 Max: _____

Audiometry: _____

| Normal | | | Abnormal | |
|---|---|---|---|---|
| ☐ | 1. | Head | ☐ | |
| ☐ | 2. | Eyes (pupils), ENT | ☐ | |
| ☐ | 3. | Teeth | ☐ | |
| ☐ | 4. | Chest | ☐ | |
| ☐ | 5. | Lungs | ☐ | |
| ☐ | 6. | Heart | ☐ | |
| ☐ | 7. | Abdomen | ☐ | |
| ☐ | 8. | Genitalia | ☐ | |
| ☐ | 9. | Neurologic | ☐ | |
| ☐ | 10. | Skin | ☐ | |
| ☐ | 11. | Physical Maturity | ☐ | |
| ☐ | 12. | Spine, Back | ☐ | |
| ☐ | 13. | Shoulders, Upper extremities | ☐ | |
| ☐ | 14. | Lower extremities | ☐ | |

Assessment: ☐ Full participation ☐ Limited participation (describe limitations, restrictions):

_____

_____

☐ Participation contraindicated (list reasons):

_____

_____

Recommendations (equipment, taping, rehabilitation, etc.):

_____

_____

DATE OF PHYSICIAL: _____ PHYSICIAN'S SIGNATURE: _____

PHYSICIAN'S PHONE: ( )_____ PRINT PHYSICIAN'S NAME: _____