



**PRE-PARTICIPATION  
PHYSICAL EVALUATION**

*To be completed by athlete and parent:*

Date: \_\_\_\_\_

Student-Athlete's Name: \_\_\_\_\_  
*Last First Middle*

Address: \_\_\_\_\_  
*Street*

\_\_\_\_\_  
*City/State Zip* Phone (401) \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Date Of Birth: \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_

Emergency Phone: ( ) \_\_\_\_\_

Family Doctor: \_\_\_\_\_

Address: \_\_\_\_\_  
*Street*

\_\_\_\_\_  
*City/State Zip*

Phone: ( ) \_\_\_\_\_

## Pre-Participation History and Physical Exam

### HISTORY

#### General

	Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?	___	___
2. Do you have an ongoing or chronic illness? _____	___	___
3. Have you ever been hospitalized overnight?	___	___
4. Have you ever had surgery?	___	___
5. Are you currently taking any prescription or non-prescription (over the counter) medications or pills?	___	___
a. prescription _____	___	___
b. non-prescription _____ <i>(over the counter)</i>	___	___
6. Do you have any allergies (for example: to pollen, medicine, or stinging insects)? If yes, which one(s)? _____	___	___
7. Do you have any dental prosthetic devices (i.e., bridges, crowns)?	___	___
8. Have you had any problems with your eyes or vision? _____	___	___
9. Do you wear glasses, contacts, or protective eyewear? _____	___	___
10. Do you have any current skin problems? _____	___	___
11. Have you ever fainted or become ill from exercising in the heat?	___	___
12. If you smoke, how many packs per day? _____	___	___
13. Do you have only one of a normally paired organ (i.e. kidney, lung, eye, testicle)? If yes, which one(s)? _____	___	___

#### Heart

	Yes	No
1. Have you ever passed out during or after exercise?	___	___
2. Have you ever been dizzy after exercise?	___	___
3. Have you ever had chest pain during or after exercise?	___	___
4. Have you ever had racing of your heart or skipped heartbeats?	___	___
5. Have you ever been told you have a heart murmur?	___	___
6. Has any family member or relative died of heart problems or of sudden death before age 50?	___	___
7. Have you had a viral infection (for example: mononucleosis) within the last year? If yes, what? _____	___	___
8. Has a physical ever denied or restricted your participation in sports for any heart problems?	___	___

#### Lung

	Yes	No
1. Do you cough, wheeze, or have trouble breathing during or after activity?	___	___
2. Do you have asthma?	___	___
3. Do you use an inhaler?	___	___

#### Musculo-Skeletal

	Yes	No
1. 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)?	___	___
2. Have you ever had a sprain, strain, or swelling after injury which prevented you from participation? _____	___	___
3. Have you broken or fractured any bones or dislocated any joints?	___	___

**Head**

1. Have you had a head injury or a concussion? \_\_\_\_\_
2. Have you ever been knocked out, become unconscious, or lost your memory? \_\_\_\_\_
3. Have you ever had a seizure? \_\_\_\_\_
4. Have you ever had a stinger, burner, or numbness in your arms, hands, legs or feet?  
If yes, which one(s)? \_\_\_\_\_

**Yes No**

_____	_____
_____	_____
_____	_____
_____	_____

**Nutrition**

1. Do you skip meals during the day? \_\_\_\_\_
2. Do you use laxatives, diuretics, or stimulants to control your weight?  
If yes, which one(s)? \_\_\_\_\_
3. Do you feel disgusted, depressed, or guilty about your eating? \_\_\_\_\_
4. Do you self-induce vomiting after eating? \_\_\_\_\_
5. Do you restrict certain types of foods?  
If yes, which one(s)? \_\_\_\_\_
6. Have you ever taken nutritional supplements?  
If yes, which one(s)? \_\_\_\_\_
7. Do you have a food allergy?  
If yes, which one(s)? \_\_\_\_\_
8. Do you want to weigh more or less than you do now? \_\_\_\_\_

**Yes No**

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**FEMALES ONLY**

1. When was your last menstrual period? \_\_\_\_\_
2. How often do your periods occur? \_\_\_\_\_
3. Have you ever gone 4 months without getting a period? \_\_\_\_\_

**Parental Permission and Authorization for Treatment**

We hereby give our consent for \_\_\_\_\_ to represent his/her school in interscholastic athletics. If in the event of injury or accident either en route to the event, at the event, or en route back from the event, we also give our consent for the school to obtain any and all medical care that is deemed reasonably necessary for the welfare of the student. We realize that all reasonable efforts will be made to contact us if the above does occur.

We further state that we have completed that part of this form which requires us to list all previous injuries or conditions that are known to us and that the form is completed correct and true.

Name of Primary Medical Insurance: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Parent or Guardian (PRINT): \_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

NAME: \_\_\_\_\_

**PHYSICAL EXAMINATION**

SPORT(S): \_\_\_\_\_

Age: \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_  
Pulse \_\_\_\_\_ BP \_\_\_\_\_  
Vision R \_\_\_\_\_ L \_\_\_\_\_ Corrected: Y N

	Normal	Explanation
<b>Medical</b>		
General		
Skin		
HEENT		
Lymph Nodes		
Heart		
Lungs		
Abdomen		
Genitalia (males only)		
Pulses		
<b>Musculo-Skeletal</b>		
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Calf		
Ankle/Foot		
Neurologic		

**Immunizations**

1. When was your last tetanus shot? \_\_\_\_\_
2. When was the date of your measles immunization? \_\_\_\_\_

**Identified Problems:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**Review by Physician:**

- \_\_\_\_ No Athletic Participation
- \_\_\_\_ Limited Participation, e.g., \_\_\_\_\_
- \_\_\_\_ Clearance Withheld Until: \_\_\_\_\_
- \_\_\_\_ Full Unlimited Participation

**Athlete requesting clearance in the following sport(s):** \_\_\_\_\_

Cleared: Yes // No //

Recommendations \_\_\_\_\_

Name of Physician, NP, or PA \_\_\_\_\_ Date \_\_\_\_\_

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

Signature of Physician \_\_\_\_\_, MD or DO  
(Physician's signature required if examination performed by nurse practitioner or physician's assistant)