

Preparticipation Physical Evaluation (Page 1 of 2)

This completed form must be kept on file by the school. This form is valid for 365 calendar days from the date of the evaluation as written on page 2.

Part 1. Student Information (to be completed by student or parent).

Student's Name: _____ Sex: _____ Age: _____ Date of Birth: _____ / _____ / _____

School: _____ Grade in School: _____ Sport(s): _____

Home Address: _____ Home Phone: (_____) _____

Name of Parent/Guardian: _____

Person to Contact in Case of Emergency: _____

Relationship to Student: _____ Home Phone Number: (_____) _____ Work Phone Number: (_____) _____

Personal/Family Physician: _____ City/State: _____ Office Phone: (_____) _____

Part 2. Medical History (to be completed by student or parent). Explain "yes" answers below. Circle questions you don't know answers to.

	Yes	No		Yes	No	
1. Have you had a medical illness or injury since your last check up or sports physical?	_____	_____	26. Have you ever become ill from exercising in the heat?	_____	_____	
2. Do you have an ongoing chronic illness?	_____	_____	27. Do you cough, wheeze, or have trouble breathing during or after activity?	_____	_____	
3. Have you ever been hospitalized overnight?	_____	_____	28. Do you have asthma?	_____	_____	
4. Have you ever had surgery?	_____	_____	29. Do you have seasonal allergies that require medical treatment?	_____	_____	
5. Are you currently taking any prescription or nonprescription (over the-counter) medications or pills or using an inhaler?	_____	_____	30. 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 for teeth, hearing aid)?	_____	_____	
6. Have you ever taken any supplements or vitamins or steroids to help you gain or lose weight or improve your performance?	_____	_____	31. Have you had any problems with your eyes or vision?	_____	_____	
7. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	_____	_____	32. Do you wear glasses, contacts, or protective eyewear?	_____	_____	
8. Have you ever been short of breath for no obvious reason?	_____	_____	33. Have you ever had a rash or hives develop during or after exercise?	_____	_____	
9. Have you ever passed out during or after exercise?	_____	_____	34. Have you broken or fractured any bones or dislocated any joints?	_____	_____	
10. Have you ever been dizzy during or after exercise?	_____	_____	35. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	_____	_____	
11. Have you ever had chest pain during or after exercise?	_____	_____	<i>If yes, check appropriate blank and explain below.</i>			
12. Do you get tired more quickly than your friends do during exercise?	_____	_____	___ Head ___ Elbow ___ Hip			
13. Have you ever had racing of your heart or skipped heartbeats?	_____	_____	___ Neck ___ Forearm ___ Thigh			
14. Have you had high blood pressure or high cholesterol?	_____	_____	___ Back ___ Wrist ___ Knee			
15. Have you ever been told you have a heart murmur?	_____	_____	___ Chest ___ Hand ___ Shin/Calf			
16. Has any family member or relative been diagnosed with and/or died of heart problems or sudden death before age 50?	_____	_____	___ Shoulder ___ Finger ___ Ankle			
17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	_____	_____	___ Upper Arm ___ Foot			
18. Has a physician ever denied or restricted your participation in sports for any heart problems?	_____	_____	36. Do you want to weigh more or less than you do now?	_____	_____	
19. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	_____	_____	37. Do you lose weight regularly to meet weight requirements for your sport?	_____	_____	
20. Have you ever had a head injury or concussion?	_____	_____	38. Do you feel stressed out?	_____	_____	
21. Have you ever been knocked out, become unconscious, or lost your memory?	_____	_____	39. Record the dates of your most recent immunizations (shots) for:			
22. Have you ever had a seizure?	_____	_____	Tetanus: _____ Measles: _____			
23. Do you have frequent or severe headaches?	_____	_____	Hepatitis B: _____ Chickenpox: _____			
24. Have you ever had numbness or tingling in your arms, hands, legs, or feet?	_____	_____	FEMALES ONLY (optional)			
25. Have you ever had a stinger, burner, or pinched nerve?	_____	_____	40. When was your first menstrual period? _____			
			41. When was your most recent menstrual period? _____			
			42. How much time do you usually have from the start of one period to the start of another? _____			
			43. How many periods have you had in the last year? _____			
			44. What was the longest time between periods in the last year? _____			

Explain "Yes" answers here:

I (we) hereby state, to the best of my (our) knowledge, my (our) answers to the above questions are complete and correct.

Signature of Student: _____ Date: _____ Signature of Parent/Guardian: _____ Date: _____

NOTE: CONSENT AND HIPAA RELEASE FORMS THAT MUST BE SIGNED BY BOTH THE PARENT AND THE STUDENT ARE ON A SEPARATE SHEET.
NOTE: HISTORY AND ALL CONSENT FORMS MUST BE COMPLETED PRIOR TO PHYSICAL EXAMINATION

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Part 3. Physical Examination (to be completed by licensed physician, licensed chiropractic physician or nurse practitioner).

Student's Name: _____ Date of Birth: ____ / ____ / ____

Height: _____ Weight: _____ Pulse: _____ Blood Pressure: ____ / ____ (____ / ____ , ____ / ____)

Visual Acuity: Right 20/____ Left 20/____ Corrected: Yes No Pupils: Equal _____ Unequal _____

FINDINGS	NORMAL	ABNORMAL FINDINGS	INITIALS *
MEDICAL			
1. Appearance	_____	_____	_____
2. Eyes/Ears/Nose/Throat	_____	_____	_____
3. Lymph Nodes	_____	_____	_____
4. Heart	_____	_____	_____
5. Pulses (Radial & Femoral)	_____	_____	_____
6. Lungs	_____	_____	_____
7. Abdomen	_____	_____	_____
8. Genitalia (males only)	_____	_____	_____
9. Skin	_____	_____	_____
MUSCULOSKELETAL			
10. Neck	_____	_____	_____
11. Back	_____	_____	_____
12. Shoulder/Arm	_____	_____	_____
13. Elbow/Forearm	_____	_____	_____
14. Wrist/Hand	_____	_____	_____
15. Hip/Thigh	_____	_____	_____
16. Knee	_____	_____	_____
17. Leg/Ankle	_____	_____	_____
18. Foot	_____	_____	_____
19. Stigmata of Marfan's	_____	_____	_____

*- station-based examination only

ASSESSMENT OF EXAMINING PHYSICIAN/NURSE PRACTITIONER

I hereby certify that each examination listed above was performed by myself or an individual under my direct supervision with the following conclusion(s):

____ Cleared without limitation.

____ Not cleared for: _____ Reason: _____

____ Cleared after completing evaluation/rehabilitation for: _____

____ Referred to _____ For: _____

Recommendations: _____

Name of Physician/Nurse Practitioner (print or type): _____ Date: _____

Address: _____

Signature of Physician/Nurse Practitioner: _____

ASSESSMENT OF PHYSICIAN TO WHOM REFERRED (if applicable)

I hereby certify that the examination(s) for which referred was performed by myself or an individual under my direct supervision with the following conclusion(s):

____ Cleared without limitation.

____ Not cleared for: _____ Reason: _____

____ Cleared after completing evaluation/rehabilitation for: _____

Recommendations: _____

Name of Physician (print or type): _____ Date: _____

Address: _____

Signature of Physician: _____

DISCLOSURE OF HEALTH INFORMATION AUTHORIZATION FORM

I hereby authorize the release and disclosure of the personal health information of _____ ("Student"), as described below, to _____ ("School").

The information described below may be released to the School principal or assistant principal, athletic director, coach, athletic trainer, physical education teacher, school nurse or other member of the School's administrative staff as necessary to evaluate the Student's eligibility to participate in school sponsored activities, including but not limited to interscholastic sports programs, physical education classes or other classroom activities.

Personal health information of the Student which may be released and disclosed includes records of physical examinations performed to determine the Student's eligibility to participate in school sponsored activities, including but not limited to the Pre-participation Evaluation form or other similar document required by the School prior to determining eligibility of the Student to participate in classroom or other School sponsored activities; records of the evaluation, diagnosis and treatment of injuries which the Student incurred while engaging in school sponsored activities, including but not limited to practice sessions, training and competition; and other records as necessary to determine the Student's physical fitness to participate in school sponsored activities.

The personal health information described above may be released or disclosed to the School by the Student's personal physician or physicians; a physician or other health care professional retained by the School to perform physical examinations to determine the Student's eligibility to participate in certain school sponsored activities or to provide treatment to students injured while participating in such activities, whether or not such physicians or other health care professionals are paid for their services or volunteer their time to the School; or any other EMT, hospital, physician or other health care professional who evaluates, diagnoses or treats an injury or other condition incurred by the student while participating in school sponsored activities.

I understand that the School has requested this authorization to release or disclose the personal health information described above to make certain decisions about the Student's health and ability to participate in certain school sponsored and classroom activities, and that the School is a not a health care provider or health plan covered by federal HIPAA privacy regulations, and the information described below may be redisclosed and may not continue to be protected by the federal HIPAA privacy regulations. I also understand that the School is covered under the federal regulations that govern the privacy of educational records, and that the personal health information disclosed under this authorization may be protected by those regulations.

I also understand that health care providers and health plans may not condition the provision of treatment or payment on the signing of this authorization; however, the Student's participation in certain school sponsored activities may be conditioned on the signing of this authorization.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by a health care provider in reliance on this authorization, by sending a written revocation to the school principal (or designee) whose name and address appears below.

Name of Principal: _____

School Address: _____

This authorization will expire when the student is no longer enrolled as a student at the school.

NOTE: IF THE STUDENT IS UNDER 18 YEARS OF AGE, THIS AUTHORIZATION MUST BE SIGNED BY A PARENT OR LEGAL GUARDIAN TO BE VALID. IF THE STUDENT IS 18 YEARS OF AGE OR OVER, THE STUDENT MUST SIGN THIS AUTHORIZATION PERSONALLY.

Student's Signature

Birth date of Student, including year

Name of Student's personal representative, if applicable I am the Student's (check one): _____ Parent _____ Legal Guardian (documentation must be provided)

Signature of Student's personal representative, if applicable

Date

A copy of this signed form has been provided to the student or his/her personal representative

THE STUDENT SHALL NOT BE CLEARED TO PARTICIPATE IN ATHLETICS UNTIL THIS FORM HAS BEEN SIGNED AND RETURNED TO THE SCHOOL