



Athletic Pre-Participation Physical Examination

PART I- Personal and Emergency Information

This part to be completed by parent and student.

PERSONAL INFORMATION

Student's Name (Last, First, M.I.) _____ Gender _____

Date of Birth _____ Age _____ Grade _____ School Year _____

Home Address _____

City _____ State _____ Zip Code _____

Home Phone # _____

EMERGENCY INFORMATION

Primary Emergency Contact Person's Name _____ Relationship _____

Address _____ Emergency Contact Telephone # _____

Secondary Emergency Contact Person's Name _____ Relationship _____

Address _____ Emergency Contact Telephone # _____

Medical Insurance Carrier _____ Policy Number _____

Address _____ Telephone Number _____

Family Physician's Name _____

Address _____ Telephone Number _____

Student's Allergies _____

Student's Health Conditions (s) of Which an Emergency Physician Should be Aware _____

Student's Prescription Medications _____

PART II – Medical/Health History

This part to be completed by parent and student. Check the appropriate response to each item.

	Yes	No		Yes	No
1. Have you ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	18. Do you use any special equipment (e.g., knee brace)?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever had surgery of any kind (e.g., tonsillectomy)?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever passed out or nearly passed out DURING exercise?	<input type="checkbox"/>	<input type="checkbox"/>	20. Have you ever had an injury, like a sprain, muscle, or ligament tear, or tendonitis?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever passed out or nearly passed out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, circle affected area below:		
5. Have you ever had discomfort, pain or pressure in your chest during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have you had any broken or fractured bones or dislocated joints?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, circle below:		
7. Have you ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	22. 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?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, circle below:		
9. Has anyone in your family died of heart problems before 50?	<input type="checkbox"/>	<input type="checkbox"/>	Head Neck Shoulder Upper arm Elbow Forearm Hand/ Fingers Chest		
10. Do you have any skin problems? (itching, rashes, acne)	<input type="checkbox"/>	<input type="checkbox"/>	Upper back Lower back Hip Thigh Knee Calf/ Shin Ankle Foot/ Toes		
11. Have you ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	23. Are you missing one of any paired organs (e.g., eyes)?	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you ever been knocked out or unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	24. Have you ever been diagnosed with any form of asthma?	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you ever had a seizure or suffer from epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>	25. Are you using an inhaler for asthma?	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you ever had a stinger, burner, or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	26. Are you diabetic?	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you ever had heat related problems?	<input type="checkbox"/>	<input type="checkbox"/>	27. Do you administer insulin to yourself?	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever been dizzy or passed out in the heat?	<input type="checkbox"/>	<input type="checkbox"/>	28. Do you have a history of sickle-cell anemia in your family?	<input type="checkbox"/>	<input type="checkbox"/>
17. Do you cough heavily, or breathe heavily during or after activity?	<input type="checkbox"/>	<input type="checkbox"/>	29. Have you had any other medical problems?	<input type="checkbox"/>	<input type="checkbox"/>
			30. Have you had a medical problem or injury within the last year?	<input type="checkbox"/>	<input type="checkbox"/>
			31. When was your last tetanus shot?	<input type="checkbox"/>	<input type="checkbox"/>

Please explain any YES answers from questions 1-31:

No(s).	Explain “YES” answers here:

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Parent’s/Guardian’s signature _____ Date _____

PART III – Physical Examination

This part must be completed by a health care provider.

Patient Name _____ Age _____

Height _____ Weight _____ BP _____ / _____ Pulse _____

Vision: R – 20/____ L – 20/____ Corrected (circle one) Y N

	Normal	Abnormal	Comment
HEART			
Rhythm (Regular/Irregular)			
Murmur (supine)			
Murmur (standing)			
ENT			
Lungs			
Skin			
Abdominal			
Genitalia			
Musculoskeletal			
Neck			
Shoulder			
Elbow			
Wrist			
Hand			
Back			
Knee			
Ankle			
Foot			
Dental			
Other			

After having reviewed the data above and the student's medical history, I make the following recommendations on participation in athletics:

1. Cleared
2. Cleared after additional evaluation for _____
3. Cleared only to participate in the sports of (circle all that apply) BASKETBALL CHEERLEADING RUNNING

Recommendations/Referrals (attach additional if necessary) _____

I have examined the physical condition of the student and find the said student to be physically fit to practice for and participate in interscholastic athletic contests.

Authorized Signature

Date

Provider's Name (please print)	
Address:	
City/State/Zip	
Phone	