



Pre-Participation Physical Form

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Has a doctor ever denied or restricted your participation in sports for any reason? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have an ongoing medical condition (i.e.: Diabetes, asthma)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently taking any prescription or nonprescription (over the counter) medications? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have allergies to medicines, pollens, foods, or stinging insects? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever passed out or nearly passed out during exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever passed out or nearly passed out after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had discomfort, pain or pressure in your chest during exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Does your heart race or skip beats during exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Has a doctor ever told you that you have (check all that apply): | | |

- | | |
|--|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> A heart Murmur |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> A heart Infection |

- | | | |
|--|--------------------------|--------------------------|
| 10. Has a doctor ever ordered a test for your heart (i.e.: ECG, echocardiogram) | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Has anyone in your family died for no apparent reason? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Does anyone in your family have a heart problem? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Has any family member or relative died of heart problems or of sudden death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Does anyone in your family have Marfan syndrome? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever spent the night in the hospital? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> |

- | | | |
|---|--------------------------|--------------------------|
| 17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis that caused you to miss a practice or game? If yes, circle affected area below: | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you ever had any broken or fractured bones or dislocated joints? If yes, circle below: | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. 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? If yes, circle below: | <input type="checkbox"/> | <input type="checkbox"/> |

- | | | | |
|--------------|------------|-----------|-----------|
| Head | Shoulder | Upper Arm | Elbow |
| Upper Back | Lower Back | Hip | Neck |
| Thigh | Knee | Calf/shin | Forearm |
| Hand/fingers | Ankle | Chest | Foot/toes |

- | | YES | NO |
|--|--------------------------|--------------------------|
| 20. Have you ever had a stress fracture? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Do you regularly use a brace or assistive device? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Has a doctor ever told you that you have asthma or allergies? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Do you cough, wheeze, or have difficulty breathing during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Is there anyone in your family who has asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Have you ever used an inhaler or taken asthma medicine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Have you had infectious mononucleosis (mono) within the last month? | <input type="checkbox"/> | <input type="checkbox"/> |

| | YES | NO |
|--|--------------------------|--------------------------|
| 29. Do you have any rashes, pressure sores, or other skin problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Have you had a herpes skin infection? | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Have you ever had a head injury or concussion? | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Have you ever been hit in the head and been confused or lost your memory? | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Do you get headaches with exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. Have you ever been unable to move your arms or legs after being hit or falling? | <input type="checkbox"/> | <input type="checkbox"/> |
| 37. When exercising in the heat, do you have severe muscle cramps or become ill? | <input type="checkbox"/> | <input type="checkbox"/> |
| 38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 39. Have you ever had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 40. Do you wear glasses or contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 41. Do you wear protective eyewear, such as goggles or a face shield? | <input type="checkbox"/> | <input type="checkbox"/> |
| 42. Are you happy with your weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 43. Are you trying to gain or lose weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 44. Has anyone suggested your change your weight or eating habits? | <input type="checkbox"/> | <input type="checkbox"/> |
| 45. Do you limit or carefully control your eating habits? | <input type="checkbox"/> | <input type="checkbox"/> |
| 46. Do you have any concerns you would like to discuss with a doctor? If yes, explain. | <input type="checkbox"/> | <input type="checkbox"/> |
| 47. Have you ever had a menstrual period? If yes, explain* | <input type="checkbox"/> | <input type="checkbox"/> |
| 48. How old were you when you had your first menstrual period?* | <input type="checkbox"/> | <input type="checkbox"/> |
| 49. How many periods have you had in the last 12 months?* | <input type="checkbox"/> | <input type="checkbox"/> |

FEMALES ONLY*

Explain "Yes" answers here: _____

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

Signature of athlete: _____ Date: _____

Signature of parent/guardian: _____ Date: _____

PHYSICAL EXAMINATION FORM

Height: _____ Weight: _____ %of body fat: _____

Pulse: _____ BP: _____ / _____ (_____ / _____, _____ / _____)

Vision: R 20/ _____ L 20/ _____ Corrected: **Y N** Pupils: Equal _____ Unequal _____

Follow-up Questions on More Sensitive Issues

| | YES | NO |
|--|--------------------------|--------------------------|
| 1. Do you feel stressed out or under a lot of pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you ever feel so sad or hopeless that you stop doing some of your activities for more than a few days? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you feel safe? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. During the past 30 days, did you use chewing tobacco, snuff or dip? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. During the past 30 days have you tried at least 1 drink of alcohol? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever taken steroid pills or shots without a doctor's prescription? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever taken any supplements to help you lose or gain weight or to improve your performance? | <input type="checkbox"/> | <input type="checkbox"/> |

Questions from the Youth Risk Behavior Survey (<http://www.cdc.gov/HealthlyYouth/yrbs/index.htm>)
on guns, seatbelts, unprotected sex, domestic violence, drugs, etc.

Notes: _____

| Medical | Normal | Abnormal Findings | Initials* |
|------------------------------|--------|-------------------|-----------|
| Appearance | | | |
| Eyes/ears/nose/throat | | | |
| Hearing | | | |
| Lymph nodes | | | |
| Murmurs | | | |
| Heart | | | |
| Pulses | | | |
| Lungs | | | |
| Abdomen | | | |
| Genitourinary (males only)** | | | |
| Skin | | | |

| Musculoskeletal | Normal | Abnormal Findings | Initials* |
|--------------------|--------|-------------------|-----------|
| Neck | | | |
| Back | | | |
| Shoulder/arm | | | |
| Elbow/Forearm | | | |
| Wrist/hand/fingers | | | |
| Hip/thigh | | | |
| Knee | | | |
| Leg/ankle | | | |
| Foot/toes | | | |

*Multiple-examiner set-up only

**Having a 3rd party present is recommended

Notes: _____

MEDICAL CLEARANCE

Full contact/collision level (full, unrestricted participation)

Limited contact/impact

Non contact: Strenuous

Non contact: non-strenuous

Clearance deferred or no participation at this time because:

Needs clearance by specialist:

Orthopedist: ____

Cardiologist: ____

Other: ____

Must complete rehabilitation for current condition(s) prior to participation

Name of Physician (Print/Type): _____

Address: _____

Phone: _____

Physician's Signature: _____

Date: _____

Physician's Office Stamp Here:

