Pre-Participation Physical Form

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

9. Has a doctor ever told you that you have (check all that apply):

☐ High blood pressure ☐ A heart Murmur
☐ High cholesterol ☐ A heart Infection

	YES	NO
10. Has a doctor ever ordered a test for your heart (i.e.: ECG, echocardiogram)	☐	☐
11. Has anyone in your family died for no apparent reason?	☐	☐
12. Does anyone in your family have a heart problem?	☐	☐
13. Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
14. Does anyone in your family have Marfan syndrome?	☐	☐
15. Have you ever spent the night in the hospital?	☐	☐
16. Have you ever had surgery?	☐	☐
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:	☐	☐
18. Have you ever had any broken or fractured bones or dislocated joints? If yes, circle below:	☐	☐
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:	☐	☐

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?	☐	☐
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
22. Do you regularly use a brace or assistive device?	☐	☐
23. Has a doctor ever told you that you have asthma or allergies?	☐	☐
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
25. Is there anyone in your family who has asthma?	☐	☐
26. Have you ever used an inhaler or taken asthma medicine?	☐	☐
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
28. Have you had infectious mononucleosis (mono) within the last month?	☐	☐

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

FEMALES ONLY*

Explain "Yes" answers here: ____

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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?	☐	☐
2. Do you ever feel so sad or hopeless that you stop doing some of your activities for more than a few days?	☐	☐
3. Do you feel safe?	☐	☐
4. Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke?	☐	☐
5. During the past 30 days, did you use chewing tobacco, snuff or dip?	☐	☐
6. During the past 30 days have you tried at least 1 drink of alcohol?	☐	☐
7. Have you ever taken steroid pills or shots without a doctor's prescription?	☐	☐
8. Have you ever taken any supplements to help you lose or gain weight or to improve your performance?	☐	☐

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

Notes: ____

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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: ____

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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: