

# SPORTS PREPARTICIPATION HEALTH EVALUATION

NOTE: EXAM MUST BE PERFORMED AFTER MAY 15TH OF PREVIOUS SCHOOL YEAR TO BE VALID FOR CURRENT SCHOOL YEAR

Name: \_\_\_\_\_ (LAST) (FIRST) (MI) Sex: M F Today's Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 \_\_\_\_\_ Grade: \_\_\_\_\_ School: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Health or Accident Insurance Co.: \_\_\_\_\_  
 Parent/Guardian: \_\_\_\_\_ Sports Activities: \_\_\_\_\_  
 Family Doctor: \_\_\_\_\_

**PLEASE CIRCLE YES OR NO TO THE FOLLOWING QUESTIONS:**

- |   |   |
|---|---|
| <p><input type="checkbox"/> Y <input type="checkbox"/> N 1. Currently taking any prescribed or over-the-counter medicines or using an inhaler?</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N 2. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N 3. Any allergies? (medication, foods, bee stings, etc.)</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N 4. Currently under treatment for any medical problem?</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N 5. Previous hospitalization or serious illnesses?</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N 6. Past surgeries?</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N 7. Prior sports injuries?</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N 8. Wear glasses or contacts?</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N 9. Hearing problems?</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N 10. Dental problems? (braces, loose or false teeth, retainer, etc.)</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N 11. Any missing organs? (kidney, spleen, eye, testicle, etc.)</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N 12. Current or recurring skin problems (impetigo, acne, herpes, athlete's foot, cold sores, etc.)</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N 13. Have you ever passed out during or after exercise?</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N 14. Have you ever been dizzy during or after exercise?</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N 15. Have you ever had chest pain during or after exercise?</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N 16. Have you ever had high blood pressure, high cholesterol, racing of the heart, skipped heartbeats or irregular heartbeats?</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N 17. Have you ever been told you have a heart murmur?</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N 18. Has a physician ever denied or restricted your participation in sports for any heart problem?</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N 19. Has a family member or relative died of heart problems or of sudden death before age 50?</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N 20. Any family history of other conditions such as Marfan's syndrome, irregular heartbeat, hypertrophic cardiomyopathy?</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N 21. Any recurrent wheezing or asthma?</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N 22. Do you have excessive coughing, wheezing or trouble breathing during or after exercise?</p> | <p><input type="checkbox"/> Y <input type="checkbox"/> N 23. Any muscle weakness, numbness in arms or legs, history of stinger, burner, or pinched nerve?</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N 24. Do you have frequent or severe headaches?</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N 25. Have you ever been knocked unconscious or had a concussion? If so, how many times? _____</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N 26. Any presence of hernia; absent or undescended testicles?</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N 27. Have you ever experienced any heat related injuries, such as heat cramps, heat exhaustion or passed out in the heat?</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N 28. Have you ever sprained, dislocated, broken or fractured any bones or joints?</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N 29. Do you want to weigh more or less than you do now?</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N 30. Do you lose weight regularly to meet weight requirements for your sport?</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N 31. Do you feel stressed out?</p> <p><b>FEMALES ONLY</b></p> <p><input type="checkbox"/> Y <input type="checkbox"/> N 32. At what age did your menstrual periods begin? _____</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N 33. What was the longest time between periods last year? _____</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N 34. Date of last menstrual period? _____</p> <p><b>VACCINATIONS</b><br/>         Please record the dates of most recent vaccinations, if available:</p> <p>Tetanus _____ Hepatitis B _____<br/>         Measles _____ Chickenpox _____</p> |
|---|---|

USE THIS SPACE FOR DETAILS OF ANY "YES" ANSWERS ABOVE OR ANY ADDITIONAL HEALTH HISTORY

I hereby state that to the best of my knowledge the above answers are correct.  
 I authorize Dr. \_\_\_\_\_ to perform his/her preparticipation physical evaluation.

\_\_\_\_\_  
 PARENT/GUARDIAN SIGNATURE DATE  
**NOTE: Please See Back of Form for Parent/Athlete's Signature (Required).**

**ASSESSMENT:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

**DISPOSITION:** (Lab, X-Ray, EKG, PT, Referral)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

**SPORTS PARTICIPATION CLEARANCE (CIRCLE ONE)**

- A. Cleared - no restrictions  
 B. Not cleared for: (see notes)  
 1. Contact/Collision  
 2. Limited Contact/Impact  
 3. Noncontact  
     a. Strenuous  
     b. Moderately strenuous  
     c. Nonstrenuous

**NOTES:**

\_\_\_\_\_  
 EXAMINER'S SIGNATURE DATE PHONE

**PARENT/ATHLETE SECTION (PLEASE COMPLETE)**  
 NOTE: PLEASE REFER TO BACK PAGE FOR PARENT/STUDENT SIGNATURE

**PHYSICIAN SECTION**

# Preparticipation Physical Evaluation

## Classification of Sports

Contact		Noncontact		
<i>Contact/collision</i>	<i>Limited contact/impact</i>	<i>Strenuous</i>	<i>Moderately strenuous</i>	<i>Nonstrenuous</i>
Boxing	Baseball	Aerobic dance	Badminton	Archery
Field hockey	Basketball	Crew	Curling	Golf
Football	Bicycling	Fencing	Table tennis	Riflery
Ice hockey	Diving	Field (discus, javelin, shot put)		
Lacrosse	Field (high jump, pole vault)	Running/track		
Martial arts	Gymnastics	Swimming		
Rodeo	Horseback riding	Tennis		
Soccer	Skating (ice, roller)	Weight lifting		
Wrestling	Skiing (cross country, downhill, water)			
	Softball			
	Squash/handball			
	Volleyball			

*(From American Academy of Pediatrics. Committee on Sports Medicine. Recommendations for participation in competitive sports. Pediatr 1988;81 (S):737-9.)*

### TRAINING RULES

Training rules specifically prohibit drinking or possession of alcoholic beverages, abuse or possession of harmful narcotics and/or drugs, the use of tobacco in any form, or any socially unacceptable behavior such as failure to obey the civil laws of our society or the serious or habitual violation of the Board of Education's Code of Student Conduct. These training rules are to be observed throughout the year.

### PENALTIES FOR VIOLATION OF TRAINING RULES

Violation of training rules results in disqualification from interscholastic contests.

A first violation results in disqualification for ninety (90) school days, and one third of the scheduled contests in a sport season in which the student participates. A second violation results in disqualification for one (1) calendar year.

Early reinstatement may be requested for first/second violations after missing a predetermined time span and 1/3 of the athletic contests in a sports season in which the student participates. Building Athletic Chairman should be contacted for specific information on procedures.

A third violation results in disqualification for one (1) calendar year without any possibility of early reinstatement.

I hereby acknowledge that I have reviewed the items detailed under Assessment: Disposition and further realize the potential for further injuries/complications with continued sports participation. In the event of an injury sustained by my son/daughter during athletic participation, permission is hereby given authorizing emergency treatment by the team physician or attending physician. I have also read and understand the athletic training rules presented above. I give my consent for \_\_\_\_\_  
(Athlete's Name)  
to participate in interscholastic athletics at \_\_\_\_\_  
(School)  
during the current school year and to accompany the team on its out of town trips.

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Student)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Parent or Guardian)

**PLEASE TURN CARD OVER FOR PHYSICAL EXAM SUMMARY**