



## 2020-21 ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

(The parent or guardian should fill out this form with assistance from the student-athlete)

Exam Date: \_\_\_\_\_

Name: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Age: \_\_\_\_\_  
Gender: \_\_\_\_\_  
Grade: \_\_\_\_\_  
School: \_\_\_\_\_  
Sport(s): \_\_\_\_\_  
Personal Physician: \_\_\_\_\_  
Hospital Preference: \_\_\_\_\_

In case of emergency contact:  
Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Phone (Home): \_\_\_\_\_  
Phone (Work): \_\_\_\_\_  
Phone (Cell): \_\_\_\_\_  
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Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Phone (Home): \_\_\_\_\_  
Phone (Work): \_\_\_\_\_  
Phone (Cell): \_\_\_\_\_

Explain "Yes" answers on the following page.  
Circle questions you don't know the answers to.

	Y	N
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 conditional (like diabetes or asthma)?	<input type="checkbox"/>	<input type="checkbox"/>
3) Are you currently taking any prescription or nonprescription (over-the-counter) medicines or supplements? (Please specify): _____	<input type="checkbox"/>	<input type="checkbox"/>
4) Do you have allergies to medicines, pollens, foods or stringing insects? (Please specify): _____	<input type="checkbox"/>	<input type="checkbox"/>
5) Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
6) 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		
7) Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>
8) Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
9) Have you ever had an injury (sprain, muscle/ligament tear, tendinitis, etc.) that caused you to miss a practice or game? (If yes, check affected area in the box below in question 11)	<input type="checkbox"/>	<input type="checkbox"/>
10) Have you had any broken/fractured bones or dislocated joints? (If yes, check affected area in the box below in question 11):	<input type="checkbox"/>	<input type="checkbox"/>
11) Have you had a bone/joint injury that required X-rays, MRI, CT, surgery, injections, rehabilitation physical therapy, a brace, a cast or crutches? (If yes, check affected area in the box below):	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Shoulder <input type="checkbox"/> Upper Arm <input type="checkbox"/> Elbow <input type="checkbox"/> Forearm		
<input type="checkbox"/> Hand/Fingers <input type="checkbox"/> Chest <input type="checkbox"/> Upper Back <input type="checkbox"/> Lower Back <input type="checkbox"/> Hip <input type="checkbox"/> Thigh		
<input type="checkbox"/> Knee <input type="checkbox"/> Calf/Shin <input type="checkbox"/> Ankle <input type="checkbox"/> Foot/Toes		

	Y	N
12) Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>
13) Have you ever been told that you have, or have you had an X-ray for atlantoaxial (neck) instability?	<input type="checkbox"/>	<input type="checkbox"/>
14) Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>
15) Has a doctor told you that you have asthma or allergies?	<input type="checkbox"/>	<input type="checkbox"/>
16) Do you cough, wheeze or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
17) Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>
18) Have you ever used an inhaler or taken asthma medication?	<input type="checkbox"/>	<input type="checkbox"/>
19) Were you born without, are you missing, or do you have a nonfunctioning kidney, eye, testicle or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
20) Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
21) Do you have any rashes, pressure sores or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
22) Have you had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
23) Have you ever had an injury to your face, head, skull or brain (including a concussion, confusion, memory loss or headache from a hit to your head, having your "bell rung" or getting "dinged")?	<input type="checkbox"/>	<input type="checkbox"/>
24) Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
25) Have you ever had numbness, tingling or weakness in your arms or legs after being hit, falling, stingers or burners?	<input type="checkbox"/>	<input type="checkbox"/>
26) While exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>
27) 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"/>
28) Have you ever been tested for sickle cell trait?	<input type="checkbox"/>	<input type="checkbox"/>
29) Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
30) Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
31) Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
32) Are you happy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>
33) Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
34) Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>
35) Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>
36) Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>

**Females Only**

**Explain "Yes" Answers Here**

	Y	N
37) Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
38) How old were you when you had your first menstrual period?	_____	
39) How many periods have you had in the last year?	_____	



## 2020-21 ANNUAL PREPARTICIPATION PHYSICAL EXAMINATION

The physician should fill out this form with assistance from the parent or guardian.)

Student Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

### Patient History Questions: Please Tell Me About Your Child...

	Y	N
1) Has your child fainted or passed out DURING or AFTER exercise, emotion or startle?	<input type="checkbox"/>	<input type="checkbox"/>
2) Has your child ever had extreme shortness of breath during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
3) Has your child had extreme fatigue associated with exercise (different from other children)?	<input type="checkbox"/>	<input type="checkbox"/>
4) Has your child ever had discomfort, pain or pressure in his/her chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
5) Has a doctor ever ordered a test for your child's heart?	<input type="checkbox"/>	<input type="checkbox"/>
6) Has your child ever been diagnosed with an unexplained seizure disorder?	<input type="checkbox"/>	<input type="checkbox"/>
7) Has your child ever been diagnosed with exercise-induced asthma not well controlled with medication?	<input type="checkbox"/>	<input type="checkbox"/>

### Family History Questions: Please Tell Me About Any Of The Following In Your Family...

	Y	N			
8) Are there any family members who had sudden/unexpected/unexplained death before age 50? (including SIDS, car accidents, drowning or near drowning)	<input type="checkbox"/>	<input type="checkbox"/>			
9) Are there any family members who died suddenly of "heart problems" before age 50?	<input type="checkbox"/>	<input type="checkbox"/>			
10) Are there any family members who have unexplained fainting or seizures?	<input type="checkbox"/>	<input type="checkbox"/>			
11) Are there any relatives with certain conditions, such as:	<input type="checkbox"/>	<input type="checkbox"/>			
	Y	N		Y	N
Enlarged Heart	<input type="checkbox"/>	<input type="checkbox"/>	Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT)	<input type="checkbox"/>	<input type="checkbox"/>
Hypertrophic Cardiomyopathy (HCM)	<input type="checkbox"/>	<input type="checkbox"/>	Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC)	<input type="checkbox"/>	<input type="checkbox"/>
Dilated Cardiomyopathy (DCM)	<input type="checkbox"/>	<input type="checkbox"/>	Marfan Syndrome (Aortic Rupture)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Rhythm Problems	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack, Age 50 or Younger	<input type="checkbox"/>	<input type="checkbox"/>
Long QT Syndrome (LQTS)	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker or Implanted Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>
Short QT Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Deaf at Birth	<input type="checkbox"/>	<input type="checkbox"/>
Brugada Syndrome	<input type="checkbox"/>	<input type="checkbox"/>			

### Explain "Yes" Answers Here

I hereby state that, to the best of my knowledge, my answers to all of the above questions are complete and correct. Furthermore, I acknowledge and understand that my eligibility may be revoked if I have not given truthful and accurate information in response to the above questions.

Signature of Athlete \_\_\_\_\_ Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Signature of MD/DO/ND/NMD/NP/PA-C/CCSP \_\_\_\_\_ Date \_\_\_\_\_