Pre-Participation Physical Evaluation

ATTACHMENT A

Date of Exam: _____

Student's Name: _____ Sex: ____ Age: ____ Date of Birth: _____ Grade: _____

School: _____ Sport(s): _____

Address: _____ Phone: _____

Personal Physician/Provider: _____

In case of emergency, contact: Name: _____ Relationship: _____

Telephone: (Home) _____ (Work) _____ (Cell) _____ (Cell) _____

Medicines and Allergies: Please list all the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking.

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

This section is to be carefully completed by the student and his/ her parent(s) or legal guardian(s) before participation in interscholastic athletics. Explain Yes answers below. Circle questions you don't know the answers to.

	GENERAL QUESTIONS	Yes	No
1.	Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2.	Do you have any ongoing medical conditions? If so, please identify below: ☐Asthma ☐Anemia ☐Diabetes ☐Infections Other:	☐	☐
3.	Have you ever spent the night in a hospital?	☐	☐
4.	Have you ever had surgery?	☐	☐
	HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5.	Have you ever passed out or nearly passed out DURING or AFTER exercise?	☐	☐
6.	Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	☐	☐
7.	Does your heart ever race or skip beats (irregular beats) during exercise?	☐	☐
8.	Has a doctor ever told you that you have any heart problems? If so, check all that apply:	☐	☐
	☐ Kawasaki disease ☐ A Heart Infection ☐ High Blood Pressure ☐ A Heart Murmur ☐ High Cholesterol Other:		
9.	Have you ever been exposed to or tested positive for COVID-19 virus? Date of (+) COVID-19 Test: Circle One:No Symptoms| Mild | Moderate | Severe	☐	☐
10.	Has a doctor ever ordered a test for your heart (for example, ECG/EKG, echocardiogram)?	☐	☐
11.	Do you get lightheaded or feel more short of breath than expected during exercise?	☐	☐
12.	Have you ever had an unexplained seizure?	☐	☐
13.	Do you get more tired or short of breath more quickly than your friends during exercise?	☐	☐
	HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
14.	Has any family member or relative died of heart problems or had an unexpected	☐	☐
15.	Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?	☐	☐
16.	Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?	☐	☐
17.	Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?	☐	☐
	BONE AND JOINT QUESTIONS	**Yes**	**No**
18.	Have you ever had an injury, like a sprain, muscle, or ligament tear, or tendinitis that caused you to miss a practice or game?	☐	☐
19.	Have you had any broken or fractured bones or dislocated joints?	☐	☐
20.	Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?	☐	☐
21.	Have you ever had a stress fracture?	☐	☐
22.	Have you been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)	☐	☐
23.	Do you regularly use a brace, orthotics or other assistive device?	☐	☐
24.	Do you have a bone, muscle or joint injury that bothers you?	☐	☐
25.	Do any of your joints become painful, swollen, feel warm, or look red?	☐	☐
26.	Do you have any history of juvenile arthritis or connective tissue disease?	☐	☐

	MEDICAL QUESTIONS	Yes	No
27.	Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
28.	Have you ever used an inhaler or taken asthma medicine?	☐	☐
29.	Is there anyone in your family who has asthma?	☐	☐
30.	Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?	☐	☐
31.	Do you have groin pain or a painful bulge or hernia in the groin area?	☐	☐
32.	Have you had infectious mononucleosis (mono) within the last month?	☐	☐
33.	Do you have any rashes, pressure sores, or other skin problems?	☐	☐
34.	Have you had a herpes or MRSA skin infection?	☐	☐
35.	Have you ever had a head injury or concussion?	☐	☐
36.	Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?	☐	☐
37.	Do you have a history of seizure disorder?	☐	☐
38.	Do you have headaches with exercise?	☐	☐
39.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
40.	Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
41.	Have you ever become ill while exercising in the heat?	☐	☐
42.	Do you get frequent muscle cramps when exercising?	☐	☐
43.	Do you or someone in your family have sickle cell trait or disease?	☐	☐
44.	Have you had any problems with your eyes or vision?	☐	☐
45.	Have you had any eye injuries?	☐	☐
46.	Do you wear glasses or contact lenses?	☐	☐
47.	Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
48.	Do you worry about your weight?	☐	☐
49.	Are you trying to or has anyone recommended that you gain or lose weight?	☐	☐
50.	Are you on a special diet or do you avoid certain types of food?	☐	☐
51.	Have you ever had an eating disorder?	☐	☐
52.	Do you have any concerns that you would like to discuss with a doctor?	☐	☐
	FEMALES ONLY		
53.	Have you ever had a menstrual period?	☐	☐
54.	How old were you when you had your first menstrual period?		
55.	How many periods have you had in the last 12 months?		
	Explain "yes" answers here:		

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

Signature of athlete _____ Signature of parent/guardian _____ Date _____