

## Participation Physical Examination

Time In: \_\_\_\_\_ Time Out: \_\_\_\_\_

This history section is to be completed by the student athlete based on the last 12 months:

**Name:** \_\_\_\_\_ **Gender:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Sport(s):** \_\_\_\_\_ **Social Security #:** \_\_\_\_\_ **Year:** \_\_\_\_\_

1. Have you been hospitalized? ..... yes no  
Have you had surgery? ..... yes no
2. Are you presently taking any medication or pills? ..... yes no
3. Have you developed any new allergies (medications, insects, bees)? ..... yes no
4. Have you passed out during or after exercise? ..... yes no  
Have you been dizzy during or after exercise? ..... yes no  
Have you had chest pain during or after exercise? ..... yes no  
Do you tire more quickly than your friends during exercise? ..... yes no
5. Have you had a high blood pressure reading this year? ..... yes no
6. Have you been told in the past 12 months that you have a chest murmur? ..... yes no
7. Have you had racing of your heart or skipped heartbeats? ..... yes no
8. Has anyone in your family died of heart problems or sudden death before age 50?... yes no
9. Do you have any skin problems? ..... yes no
10. Have you had a head injury?..... yes no  
Have you been knocked out or unconscious? ..... yes no  
Have you had a seizure? ..... yes no  
Have you had a stinger, burner, or pinched nerve? ..... yes no
11. Have had hest illness or muscle cramps? ..... yes no  
Have you been dizzy or passed out from the heat? ..... yes no
12. Do you have trouble breathing or do you cough during or after any activity? ..... yes no
13. Do you use any special equipment (pads, braces, mouth guards, etc.)? ..... yes no
14. Have you had any problems with your eyes or your vision? ..... yes no  
Do you wear contacts, glasses or protective eyewear? ..... yes no
15. Have you sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of ANY bones or joints? ..... yes no

**Circle all that apply:**

|      |           |       |       |       |      |       |
|------|-----------|-------|-------|-------|------|-------|
| Head | Shoulder  | Thigh | Neck  | Elbow | Knee | Chest |
| Back | Shin/Calf | Wrist | Ankle | Hip   | Hand | Foot  |

16. Have you had any medical illnesses (mono, diabetes, etc.) in the past 12 months? . yes no
17. Have you gained or lost more than 10 pounds in the last 12 months?..... yes no
18. Have you had a tetanus shot in the last 12 months? ..... yes no
19. Do you have any medical concerns that you would like to speak to a Doctor about? yes no

**For Women:**

20. When was your first menstrual period (age)? \_\_\_\_\_  
When was your last menstrual period (date)? \_\_\_\_\_
21. Have you skipped any period in the last 12 months? ..... yes no  
If yes, what was the longest time between your periods last year? ..... yes no
22. Are you pregnant? ..... yes no

Explain "Yes" answers: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*I hereby state to the best of my knowledge my answers to the above questions are correct.*

**Student Athlete Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Emergency Contact Information

Parent/Guardian Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Local Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Permanent Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Vital Statistics Information

| Date | Height/ Weight | Blood Pressure | Pulse | Vision Correction |
|------|----------------|----------------|-------|-------------------|
|      |                |                |       | Contacts/ Glasses |

|                   | Normal | Abnormal Findings | NP/MD Initials |
|-------------------|--------|-------------------|----------------|
| Medical           |        |                   |                |
| Cardiopulmonary   |        |                   |                |
| Pulses            |        |                   |                |
| Heart             |        |                   |                |
| Lungs             |        |                   |                |
| Skin              |        |                   |                |
| Abdominal         |        |                   |                |
| <b>ORTHOPEDIC</b> |        |                   |                |
| Neck              |        |                   |                |
| Shoulder          |        |                   |                |
| Elbow             |        |                   |                |
| Wrist             |        |                   |                |
| Hand              |        |                   |                |
| Back              |        |                   |                |
| Knee              |        |                   |                |
| Ankle             |        |                   |                |
| Foot              |        |                   |                |
| Other             |        |                   |                |

*Medical Clearance* (Circle One): CLEARED LIMITED CLEARANCE NOT CLEARED

Explain: \_\_\_\_\_

Name of Healthcare Provider (Print): \_\_\_\_\_

Healthcare Provider Signature: \_\_\_\_\_

*Orthopedic Clearance* (Circle One): CLEARED LIMITED CLEARANCE NOT CLEARED

Explain: \_\_\_\_\_

Name of Healthcare Provider (Print): \_\_\_\_\_

Healthcare Provider Signature: \_\_\_\_\_

Recommendations:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_