Preparticipation Physical Evaluation

Date:

Date of birth:

School:

Age:

Grade:

Sport(s):

Medicines and Allergies: Please list all of 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

Explain “Yes” answers below. Circle questions you don’t know the answers to.

GENERAL QUESTIONS

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 the hospital?

4. Have you ever had surgery?

HEART HEALTH QUESTIONS ABOUT YOU

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: ☐ High blood pressure  ☐ A heart murmur  ☐ High cholesterol  ☐ A heart infection  ☐ Kawasaki disease  ☐ Other:

9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)

10. Do you get lightheaded or feel more short of breath than expected during exercise?

11. Have you ever had an unexplained seizure?

12. Do you get more tired or short of breath more quickly than your friends during exercise?

HEART HEALTH QUESTIONS ABOUT YOUR FAMILY

13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?

14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?

15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?

16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?

BONE AND JOINT QUESTIONS

17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?

18. Have you ever had any broken or fractured bones or dislocated joints?

19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?

20. Have you ever had a stress fracture?

21. Have you ever been told that you have or you have had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)

22. Do you regularly use a brace, orthotics, or other assistive device?

23. Do you have a bone, muscle, or joint injury that bothers you?

24. Do any of your joints become painful, swollen, feel warm, or look red?

25. Do you have any history of juvenile arthritis or connective tissue disease?

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

Signature of athlete: ____________________________  Signature of parent/guardian: ____________________________  Date: ____________________________


HE6500  9-2081/0410
THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam

Name ___________________________ Date of birth ___________________________

Sex _______ Age _______ Grade _______ School ___________________________ Sport(s) ___________________________

1. Type of disability
2. Date of disability
3. Classification (if available)
4. Cause of disability (birth, disease, accident/trauma, other)
5. List the sports you are interested in playing

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>6. Do you regularly use a brace, assistive device, or prosthetic?</td>
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<tr>
<td>7. Do you use any special brace or assistive device for sports?</td>
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<tr>
<td>8. Do you have any rashes, pressure sores, or any other skin problems?</td>
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<tr>
<td>9. Do you have a hearing loss? Do you use a hearing aid?</td>
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<td>10. Do you have a visual impairment?</td>
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<td>11. Do you use any special devices for bowel or bladder function?</td>
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<tr>
<td>12. Do you have burning or discomfort when urinating?</td>
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<tr>
<td>13. Have you had autonomic dysreflexia?</td>
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<td>14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?</td>
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<td>15. Do you have muscle spasticity?</td>
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<tr>
<td>16. Do you have frequent seizures that cannot be controlled by medication?</td>
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</tbody>
</table>

Explain “yes” answers here

Please indicate if you have ever had any of the following.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>Atlantoaxial instability</td>
<td></td>
<td></td>
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<tr>
<td>X-ray evaluation for atlantoaxial instability</td>
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<td></td>
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<tr>
<td>Dislocated joints (more than one)</td>
<td></td>
<td></td>
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<tr>
<td>Easy bleeding</td>
<td></td>
<td></td>
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<tr>
<td>Enlarged spleen</td>
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<td></td>
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<tr>
<td>Hepatitis</td>
<td></td>
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<tr>
<td>Osteopenia or osteoporosis</td>
<td></td>
<td></td>
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<tr>
<td>Difficulty controlling bowel</td>
<td></td>
<td></td>
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<tr>
<td>Difficulty controlling bladder</td>
<td></td>
<td></td>
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<tr>
<td>Numbness or tingling in arms or hands</td>
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<td></td>
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<tr>
<td>Numbness or tingling in legs or feet</td>
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<td></td>
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<tr>
<td>Weakness in arms or hands</td>
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<td></td>
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<tr>
<td>Weakness in legs or feet</td>
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<tr>
<td>Recent change in coordination</td>
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<tr>
<td>Recent change in ability to walk</td>
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<tr>
<td>Spina bifida</td>
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<tr>
<td>Latex allergy</td>
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</tbody>
</table>

Explain “yes” answers here

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 ________________

PHYSICIAN REMINDERS
1. Consider additional questions on more sensitive issues
   • Do you feel stressed out or under a lot of pressure?
   • Do you ever feel sad, hopeless, depressed, or anxious?
   • Do you feel safe at your home or residence?
   • Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   • During the past 30 days, did you use chewing tobacco, snuff, or dip?
   • Do you drink alcohol or use any other drugs?
   • Have you ever taken anabolic steroids or used any other performance supplement?
   • Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   • Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>□ Male</th>
<th>□ Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP /</td>
<td>( )</td>
<td>Pulse</td>
<td>Vision R 20/</td>
</tr>
</tbody>
</table>

MEDICAL

NORMAL

ABNORMAL FINDINGS

- Appearance
  - Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)
- Eyes/ears/nose/throat
  - Pupils equal
  - Hearing
- Lymph nodes
- Heart*
  - Murmurs (auscultation standing, supine, +/- Valsalva)
  - Location of point of maximal impulse (PMI)
- Pulses
  - Simultaneous femoral and radial pulses
- Lungs
- Abdomen
- Genitourinary (males only)*
- Skin
  - HSV, lesions suggestive of MRSA, linea corporis
- Neurologic*

MUSCULOSKELETAL

- Neck
- Back
- Shoulder/arm
- Elbow/forearm
- Wrist/hand/fingers
- Hip/thigh
- Knee
- Leg/ankle
- Foot/toes
- Functional
  - Duck-walk, single leg hop

*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

*Consider (E) exam if in private setting. Having third party present is recommended.

*Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction
☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for ____________________________________________________________

☐ Not cleared
  ☐ Pending further evaluation
  ☐ For any sports
  ☐ For certain sports ____________________________________________________________
  Reason ____________________________________________________________

Recommendations ____________________________________________________________

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) ___________________________ Date ___________________________
Address ___________________________________________ Phone ___________________________
Signature of physician ____________________________________________________________, MD or DO
Preparticipation Physical Evaluation
CLEARANCE FORM

Name ________________________________  Sex ☐ M ☐ F  Age __________ Date of birth ________________

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for ________________________________

☐ Not cleared

☐ Pending further evaluation

☐ For any sports

☐ For certain sports

Reason ________________________________________________________________

Recommendations ____________________________________________________________

____________________________________________________________________________

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I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) ________________________________  Date ________________

Address __________________________________________  Phone _______________________

Signature of physician ___________________________________________________, MD or DO

EMERGENCY INFORMATION

Allergies ________________________________________________________________

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Other information __________________________________________________________

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