ATTENTION PARENT/GUARDIAN: The preparticipation physical examination (page 3) must be completed by a health care provider who has completed the Student-Athlete Cardiac Assessment Professional Development Module.

PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep copy of this form in the chart.) Date of Exam

Name				Date of birth
Sex	Age	Grade	School	Sport(s)
Medicines an	d Allergies: Please li	st all of the prescription and	over-the-counter medicines and supplements (he	erbal and nutritional) that you are currently taking

Do you have any allergies?

□ Yes □ No If yes, please identify specific allergy below. □ Pollens □ Food

□ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No	MEDICAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?			26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
2. Do you have any ongoing medical conditions? If so, please identify			27. Have you ever used an inhaler or taken asthma medicine?		
below: 🗆 Asthma 🗆 Anemia 🔲 Diabetes 🗇 Infections			28. Is there anyone in your family who has asthma?		
Other:			29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
4. Have you ever had surgery?			30. Do you have groin pain or a painful bulge or hernia in the groin area?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No	31. Have you had infectious mononucleosis (mono) within the last month?		
5. Have you ever passed out or nearly passed out DURING or			32. Do you have any rashes, pressure sores, or other skin problems?		
AFTER exercise?			33. Have you had a herpes or MRSA skin infection?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			34. Have you ever had a head injury or concussion?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?			35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
8. Has a doctor ever told you that you have any heart problems? If so,			36. Do you have a history of seizure disorder?		
check all that apply: High blood pressure A heart murmur			37. Do you have headaches with exercise?		
High cholesterol A heart infection			38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)			39. Have you ever been unable to move your arms or legs after being hit or falling?		
10. Do you get lightheaded or feel more short of breath than expected			40. Have you ever become ill while exercising in the heat?		
during exercise?			41. Do you get frequent muscle cramps when exercising?		
11. Have you ever had an unexplained seizure?			42. Do you or someone in your family have sickle cell trait or disease?		
12. Do you get more tired or short of breath more quickly than your friends			43. Have you had any problems with your eyes or vision?		
during exercise?			44. Have you had any eye injuries?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	45. Do you wear glasses or contact lenses?		
 Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including 			46. Do you wear protective eyewear, such as goggles or a face shield?		
drowning, unexplained car accident, or sudden infant death syndrome)?			47. Do you worry about your weight?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT			48. Are you trying to or has anyone recommended that you gain or lose weight?		
syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?			49. Are you on a special diet or do you avoid certain types of foods?		
15. Does anyone in your family have a heart problem, pacemaker, or			50. Have you ever had an eating disorder?		
implanted defibrillator?			51. Do you have any concerns that you would like to discuss with a doctor?		
16. Has anyone in your family had unexplained fainting, unexplained			FEMALES ONLY		
seizures, or near drowning?			52. Have you ever had a menstrual period?		
BONE AND JOINT QUESTIONS	Yes	No	53. How old were you when you had your first menstrual period?		
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			54. How many periods have you had in the last 12 months? Explain "yes" answers here		
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?	İ	İ	1		
21. Have you ever been told that you have or have you 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?			1		
23. Do you have a bone, muscle, or joint injury that bothers you?			1		
24. Do any of your joints become painful, swollen, feel warm, or look red?			1		
25. Do you have any history of juvenile arthritis or connective tissue disease?			1		

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

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Date

PREPARTICIPATION PHYSICAL EVALUATION 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	e)					
4. Cause of disability (birth,	, disease, accident/trauma, other)				
5. List the sports you are in	terested in playing					
				Yes	No	
6. Do you regularly use a b	6. Do you regularly use a brace, assistive device, or prosthetic?					
7. Do you use any special t	7. Do you use any special brace or assistive device for sports?					
8. Do you have any rashes,	8. Do you have any rashes, pressure sores, or any other skin problems?					
9. Do you have a hearing lo	9. Do you have a hearing loss? Do you use a hearing aid?					
10. Do you have a visual imp	10. Do you have a visual impairment?					
11. Do you use any special of	11. Do you use any special devices for bowel or bladder function?					
12. Do you have burning or o	12. Do you have burning or discomfort when urinating?					
13. Have you had autonomic	13. Have you had autonomic dysreflexia?					
14. Have you ever been diag	14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?					
15. Do you have muscle spa	15. Do you have muscle spasticity?					
16. Do you have frequent se	6. Do you have frequent seizures that cannot be controlled by medication?					

Explain "yes" answers here

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

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

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

Signature of parent/guardian

Date

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PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

Name

EVAMINATION

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).

EARITIMAT														
Height				Weigl	nt			Male	□ Female					
BP	/	(/)		Pulse		Vision F	R 20/	L 20/	Corrected	ΟΥ	ΠN	
MEDICAL									NORMAL		ABNORMAL FI	IDINGS		
Appearance														
							avatum, arachno	odactyly,						
	n > height, hype	rlaxity, my	yopia,	MVP, a	ortic	insufficiency	')							
Eyes/ears/n														
 Pupils ec Hearing 	luai													
Lymph node										+				
Heart ^a	5													
	(auscultation st	andina e	unino	+/- V	alcalv	a)								
	of point of maxi				aioaivi	u)								
Pulses														
 Simultan 	eous femoral an	d radial p	oulses											
Lungs														
Abdomen														
Genitourina	ry (males only)⁵													
Skin														
	ons suggestive o	f MRSA,	tinea c	orpori	S									
Neurologic ^c														
MUSCULOS	KELETAL													
Neck														
Back														
Shoulder/ar	m													
Elbow/forea	rm													
Wrist/hand/	fingers													
Hip/thigh														
Knee														
Leg/ankle														
Foot/toes						-								
Functional														
 Duck was 	lk cinglo log bo	n							1	1				

single leg no

^aConsider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

^bConsider GU exam if in private setting. Having third party present is recommended. ^cConsider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

Cleared for all sports without restriction

Cleared for a	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, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/quardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) (print/type)	Date
Address	Phone
Signature of physician, APN, PA	

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Date of birth _

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				
EMERGENCY INFORMATION				
Allergies				
Other information				
HCP OFFICE STAMP	SCHOOL PHYSICIAN:			

Reviewed on(Date)
Approved Not Approved Signature:

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, advanced practice nurse (APN), physician assistant (PA)	Date
Address	Phone
Signature of physician, APN, PA	
Completed Cardiac Assessment Professional Development Module	

Date_____ Signature_

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