

St. Mary's High School Pre-Participation Physical Evaluation

History:

(This page to be completed by student and parent/guardian)

Name _____ Sex _____ Date of Birth _____ Grade _____

Address _____

Parent/Guardian _____ Phone (H) _____ (C) _____

Check Sports you plan to play:

Fall: ___ Football; ___ Soccer; ___ Field Hockey; ___ Volleyball; ___ Cross Country

Winter: ___ Basketball; ___ Swimming; ___ Wrestling; ___ Ice Hockey

Spring: ___ Lacrosse; ___ Baseball; ___ Softball; ___ Golf; ___ Tennis; ___ Track & Field

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

	YES	NO		YES	NO
1 Have you had a medical illness or injury since your last check up or sports physical?	◇	◇	10 Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (IE: knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	◇	◇
Do you have an ongoing or chronic illness?	◇	◇			
2 Have you ever been hospitalized overnight?	◇	◇	11 Have you ever had any problems with your eyes or vision? Do you wear glasses, contacts or protective eyewear?	◇	◇
Have you ever had surgery?	◇	◇		◇	◇
3 Are you currently taking any prescription or non prescription (OTC) medication or pills or using an inhaler?	◇	◇	12 Have you ever had a sprain, strain, or swelling after injury?	◇	◇
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	◇	◇	Have you ever broken or fractured any bone, or dislocated any joints?	◇	◇
4 Do you have any allergies (IE: to pollen, medicine, food, or stinging insects)?	◇	◇	Have you ever had any other problems with pain or swelling in muscles, tendons, bones, or joints?	◇	◇
Have you ever had a rash or hive develop during or after exercise?	◇	◇	<i>If yes, check appropriate box & explain below.</i>		
5 Have you ever passed out during or after exercise?	◇	◇	◇ Head ◇ Back ◇ Chest ◇ Shoulder ◇ Upper Arm ◇ Elbow		
Have you ever been dizzy during or after exercise?	◇	◇	◇ Forearm ◇ Wrist ◇ Hand ◇ Finger ◇ Hip ◇ Thigh ◇ Knee		
Have you ever had chest pain during or after exercise?	◇	◇	◇ Shin/Calf ◇ Ankle ◇ Foot		
Do you get tired more quickly than your friends do during exercise?	◇	◇	13 Do you want to weight more or less than you do now?	◇	◇
Have you ever had racing of your hear or skipped heartbeats?	◇	◇	Do you lose weight regularly to meet weight requirements for your sport?	◇	◇
Have you had high blood pressure or cholesterol?	◇	◇	14 Do you feel stressed out?	◇	◇
Have you ever been told your have a heart murmur?	◇	◇	15 Record the dates of your most recent immunization (shots) for:		
Has any family member or relative died of hear problems or of sudden death before age 50?	◇	◇	Tetanus _____ Measles _____		
Have you had a sever viral infection (IE: myocarditis or mononucleosis) within the last month?	◇	◇	Hepatitis B _____ Chickenpox _____		
Has a physician ever denied or restricted your participation in sports for any heart problems?	◇	◇			
6 Do you have any current skin problems (IE: itching, rashes, acne, warts, fungus, or blisters)?	◇	◇	Females Only		
7 Have you ever had a head injury or concussion? Have you ever been knocked out, become unconscious, or lost your memory?	◇	◇	16 When was your first menstrual period? _____		
Have you ever had a seizure?	◇	◇	When was your most recent menstrual cycle? _____		
Do you have or severe headaches?	◇	◇	How much time do you usually have from the start of one period to the start of another? _____		
Have you ever had numbness or tingling in your arms, hands, legs, or feet?	◇	◇	How many periods have you had in the last year? _____		
Have you ever had a stinger burner, or pinched nerve?	◇	◇	What was the longest time between periods in the last year? _____		
8 Have you ever become ill from exercising in the heat?	◇	◇			
9 Do you cough, wheeze, or have trouble breathing during of after activity?	◇	◇			
Do you have asthma?	◇	◇			
Do you have seasonal allergies that require medical treatment?	◇	◇			

Explain "Yes" answers here: _____

We hereby state that, to the best of our knowledge, our answers to the above questions are complete & correct.

Signature of Athlete _____ Signature of Parent/Guardian _____ Date: _____

St. Mary's High School Pre-Participation Physical Evaluation

(This page to be completed by physician/nurse practitioner/physician assistant)

Physical Examination

Date of Exam _____

Name _____

Date of Birth _____

Height _____ Weight _____ % Body Fat (optional) _____ Pulse _____ BP _____

Vision R 20/ _____ L 20/ _____ Corrected? Y _____ N _____ Pupils: Equal _____ Unequal _____

	Normal	Abnormal Findings	Initials
Medical			
Appearance			
Eyes/Ear/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Musculoskeletal			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

Clearance

Cleared

Cleared after completing evaluation/rehabilitation for: _____

Not cleared for [Sport(s)]: _____ Reason: _____

Recommendation: _____

Name of physician/nurse practitioner/physician assistant _____ Date: _____

Address: _____

Signature of physician/nurse practitioner/physician assistant _____