PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: __________________________________________ Date of birth: _________________________

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

__________________________________________________________________________________________________

__________________________________________________________________________________________________

☐ Medically eligible for certain sports

__________________________________________________________________________________________________

__________________________________________________________________________________________________

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations: ___________________________________________________________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are 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 medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): __________________________________________ Date: __________________________

Address: ___________________________________________________________________________ Phone: __________________________

Signature of health care professional: ____________________________________________________________________, MD, DO, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies: _____________________________________________________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________

Medications: _____________________________________________________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________

Other information: _________________________________________________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________

Emergency contacts: _______________________________________________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________


TURN IN TO SCHOOL
HISTORY FORM
Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: ________________________________________________________________
Date of examination: _____________________________ Sport(s): _____________________________
Sex assigned at birth (F, M, or intersex): __________ How do you identify your gender? (F, M, or other): __________

List past and current medical conditions. _____________________________________________________________________________
_______________________________________________________________________________________________________________
Have you ever had surgery? If yes, list all past surgical procedures. _____________________________________________________________________________
_______________________________________________________________________________________________________________
Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).
_______________________________________________________________________________________________________________
_______________________________________________________________________________________________________________
Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).
_______________________________________________________________________________________________________________
_______________________________________________________________________________________________________________

Patient Health Questionnaire Version 4 (PHQ-4)
Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

<table>
<thead>
<tr>
<th>Feeling nervous, anxious, or on edge</th>
<th>Not at all</th>
<th>Several days</th>
<th>Over half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not being able to stop or control worrying</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS
(Explain “Yes” answers at the end of this form. Circle questions if you don’t know the answer.)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you have any concerns that you would like to discuss with your provider?</td>
<td></td>
</tr>
<tr>
<td>2. Has a provider ever denied or restricted your participation in sports for any reason?</td>
<td></td>
</tr>
<tr>
<td>3. Do you have any ongoing medical issues or recent illness?</td>
<td></td>
</tr>
</tbody>
</table>

HEART HEALTH QUESTIONS ABOUT YOU

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Have you ever passed out or nearly passed out during or after exercise?</td>
<td></td>
</tr>
<tr>
<td>5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?</td>
<td></td>
</tr>
<tr>
<td>6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?</td>
<td></td>
</tr>
<tr>
<td>7. Has a doctor ever told you that you have any heart problems?</td>
<td></td>
</tr>
<tr>
<td>8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.</td>
<td></td>
</tr>
</tbody>
</table>

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. Do you get light-headed or feel shorter of breath than your friends during exercise?</td>
<td></td>
</tr>
<tr>
<td>10. Have you ever had a seizure?</td>
<td></td>
</tr>
</tbody>
</table>

HEART HEALTH QUESTIONS ABOUT YOUR FAMILY

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?</td>
<td></td>
</tr>
<tr>
<td>12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?</td>
<td></td>
</tr>
<tr>
<td>13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?</td>
<td></td>
</tr>
</tbody>
</table>
### Bone and Joint Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Do you have a bone, muscle, ligament, or joint injury that bothers you?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Medical Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>16. Do you cough, wheeze, or have difficulty breathing during or after exercise?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Have you ever become ill while exercising in the heat?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Do you or does someone in your family have sickle cell trait or disease?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. Have you ever had or do you have any problems with your eyes or vision?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Medical Questions (continued)

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>25. Do you worry about your weight?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. Are you trying to or has anyone recommended that you gain or lose weight?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. Are you on a special diet or do you avoid certain types of foods or food groups?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. Have you ever had an eating disorder?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Females Only

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>29. Have you ever had a menstrual period?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. How old were you when you had your first menstrual period?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31. When was your most recent menstrual period?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32. How many periods have you had in the past 12 months?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Explain “Yes” answers here.**

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

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

Signature of athlete: __________________________________________________________
Signature of parent or guardian: ________________________________________________
Date: _____________________________________________________________________


Keep for Personal Records
PHYSICAL EXAMINATION FORM

Name: _________________________________________________________________ Date of birth: ________________________________________________

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?
   • 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-enhancing 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 (Q4–Q13 of History Form).

EXAMINATION

Height: ______________________ Weight: ______________________

BP: __/__/___ Pulse: __/__/___ Corrected: □ Y □ N

Vision: R 20/____ L 20/____ Corrected: □ Y □ N

MEDICAL

NORMAL ABNORMAL FINDINGS

Appearance
• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)

Eyes, ears, nose, and throat
• Pupils equal
• Hearing

Lymph nodes

Heart
• Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)

Lungs

Abdomen

Skin
• Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant Staphylococcus aureus (MRSA), or tinea corporis

Neurological

MUSCULOSKELETAL

Neck

Back

Shoulder and arm

Elbow and forearm

Wrist, hand, and fingers

Hip and thigh

Knee

Leg and ankle

Foot and toes

Functional
• Double-leg squat test, single-leg squat test, and box drop or step drop test

*Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): __________________________________________ Date: ______________________

Address: ________________________________________________________________________ Phone: ______________________

Signature of health care professional: _____________________________________________________________________, MD, DO, NP, or PA


Keep for Personal Records


Keep for Personal Records