**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

ame					Date of birth		
ex	Age	Grade S	chool		Sport(s)		
ledicines	and Allergies: Ple	ase list all of the prescription and over	r-the-cour	nter med	dicines and supplements (herbal and nutritional) that you are currently	taking	
o you ha	ve any allergies? cines	☐ Yes ☐ No If yes, please ide	entify spe		ergy below.  □ Food □ Stinging Insects		
plain "Ye	s" answers below.	Circle questions you don't know the a	nswers to				
ENERAL (	QUESTIONS		Yes	No	MEDICAL QUESTIONS	Yes	
1. Has a d		restricted your participation in sports for			Do you cough, wheeze, or have difficulty breathing during or after exercise?		
. Do you	have any ongoing me	edical conditions? If so, please identify			27. Have you ever used an inhaler or taken asthma medicine?		Ļ
		nemia   Diabetes  Infections			28. Is there anyone in your family who has asthma?		L
	ou ever spent the nigh	nt in the hospital?	-		29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		L
	ou ever had surgery?				30. Do you have groin pain or a painful bulge or hernia in the groin area?		-
	LTH QUESTIONS AB		Yes	No	31. Have you had infectious mononucleosis (mono) within the last month?	-	$\vdash$
	u ever passed out or i Rexercise?	nearly passed out DURING or			32. Do you have any rashes, pressure sores, or other skin problems?	1	+
		rt, pain, tightness, or pressure in your			33. Have you had a herpes or MRSA skin infection?  34. Have you ever had a head injury or concussion?		╁
	during exercise?	t, pain, ag.iaiooo, o. pioooaio iii yoa.			· , , , , , , , , , , , , , , , , , , ,		+
. Does yo	our 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?		
		at you have any heart problems? If so,			36. Do you have a history of seizure disorder?		T
	all that apply: n blood pressure	☐ A heart murmur			37. Do you have headaches with exercise?		T
☐ Hig	h cholesterol vasaki disease	☐ A heart infection Other:			38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
. Has a d		est for your heart? (For example, ECG/EKG,	-		39. Have you ever been unable to move your arms or legs after being hit or falling?		
). Do you	get lightheaded or fee	el 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?		L
	ou ever had an unexpl				42. Do you or someone in your family have sickle cell trait or disease?		
	get more tired or shore exercise?	t of breath more quickly than your friends			43. Have you had any problems with your eyes or vision?		L
	LTH QUESTIONS AB	OUT YOUR FAMILY	Yes	No	44. Have you had any eye injuries?		_
		relative died of heart problems or had an	163	INO	45. Do you wear glasses or contact lenses?		╄
unexpe	cted or unexplained	sudden death before age 50 (including			46. Do you wear protective eyewear, such as goggles or a face shield?		╄
		ccident, or sudden infant death syndrome)?			47. Do you worry about your weight?		╄
		have hypertrophic cardiomyopathy, Marfar right ventricular cardiomyopathy, long QT	1		48. Are you trying to or has anyone recommended that you gain or lose weight?		
		ingrit ventricular cardiomyopathy, long Q1 le, Brugada syndrome, or catecholaminergic			49. Are you on a special diet or do you avoid certain types of foods?		H
	rphic ventricular tac	•			50. Have you ever had an eating disorder?		T
	, , ,	ave a heart problem, pacemaker, or			51. Do you have any concerns that you would like to discuss with a doctor?		
	ted defibrillator?	d unexplained fainting, unexplained			FEMALES ONLY		T
	es, or near drowning				52. Have you ever had a menstrual period?		Ī
	JOINT QUESTIONS		Yes	No	53. How old were you when you had your first menstrual period?		
,	ou ever had an injury t used you to miss a p	to a bone, muscle, ligament, or tendon ractice or a game?			54. How many periods have you had in the last 12 months?		
		en or fractured bones or dislocated joints?			Explain "yes" answers here		
. Have yo	ou ever had an injury t	hat required x-rays, MRI, CT scan, a cast, or crutches?					
	ou ever had a stress fi						
. Have yo	ou ever been told that	you have or have you had an x-ray for neck tability? (Down syndrome or dwarfism)					
	•	e, orthotics, or other assistive device?					
	,	, or joint injury that bothers you?					
		e painful, swollen, feel warm, or look red?					
					1		

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HE0503

## ■ Preparticipation Physical Evaluation THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam								
Name				Date of birth				
Sex	Age	Grade	School	Sport(s)				
		-:	- 5,1001					
Type of disa								
2. Date of disa								
Classification								
		ase, accident/trauma, other)						
5. List the spo	rts you are interest	ted in playing			1	ı		
			•		Yes	No		
	-	assistive device, or prosthetic						
7. Do you use any special brace or assistive device for sports?      8. Do you have any rashes, pressure sores, or any other skin problems?								
			orobiertis?					
	9. Do you have a hearing loss? Do you use a hearing aid?  10. Do you have a visual impairment?							
		es for bowel or bladder function	n?					
· ·		nfort when urinating?						
	ad autonomic dysre							
			nermia) or cold-related (hypothermia)	illness?				
	e muscle spasticity?							
		that cannot be controlled by	medication?					
Explain "yes" ar	nswers here							
Please indicate	if vou have ever h	ad any of the following.						
	, ,	,g-			Yes	No		
Atlantoaxial inst	ability							
	X-ray evaluation for atlantoaxial instability							
<u> </u>	s (more than one)	· ·						
Easy bleeding								
Enlarged splee	า							
Hepatitis								
Osteopenia or o	steoporosis							
Difficulty contro								
Difficulty contro								
	ngling in arms or ha							
	ngling in legs or fee	et						
Weakness in ar								
Weakness in leg								
Recent change								
Recent change Spina bifida	in ability to walk							
<del>-</del>								
Latex allergy					<u> </u>	<u> </u>		
Explain "yes" ar	nswers here							
I hereby state th	nat to the hest of	my knowledge my answers	s to the above questions are comp	lete and correct				
i norchy state ti	iai, io ino posi Ul	my knowledge, my answers	to the above questions are comp	and concot.				
Signature of athlete			Signature of parent/guardian		Date			

**NOTE:** The preparticiaption physical examination must be conducted by a health care provider who 1) is a licensed physician, advanced practice nurse, or physician assistant; and 2) completed the Student-Athlete Cardiac Assessment Professional Development Module.

Date of birth

## ■ Preparticipation Physical Evaluation PHYSICAL EXAMINATION FORM

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  * Do you wear a seat belt, use a helmet, and use condoms?  2. Consider reviewing questions on cardiovascular symptoms (questions 5-14).			
EXAMINATION			
	Male □ Female		
BP / ( / ) Pulse	Vision R 20/	L 20/	Corrected □ Y □ N
MEDICAL , , , , , , , , , , , , , , , , , , ,	NORMAL	1	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 <sup>a</sup> Murmurs (auscultation standing, supine, +/- Valsalva)  Location of point of maximal impulse (PMI)			
Pulses - Simultaneous femoral and radial pulses			
Lungs			
Abdomen			
Genitourinary (males only) <sup>b</sup>			
Skin  • HSV, lesions suggestive of MRSA, tinea corporis  Neurologic c			
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 GU exam if in private setting. Having third party present is recommended. °Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.			
<ul> <li>□ Cleared for all sports without restriction</li> <li>□ Cleared for all sports without restriction with recommendations for further evaluation or</li> </ul>	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 phys participate in the sport(s) as outlined above. A copy of the physical exam is on recording a fter the athlete has been cleared for participation, a physician may rescind the to the athlete (and parents/guardians).	d in my office and can be ma clearance until the problem	ade available to the is resolved and th	e school at the request of the parents. If conditions e potential consequences are completely explained
explained to the athlete (and parents/guardians). Name of physician, advanced practice nurse (APN), physician assistant (I	PA) (print/type)		Date of exam
Address			Phone
Signature of physician, APN, PA			

## ■ 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 evaluations	uation or treatment for	
<b>'</b>		
□ Not cleared		
☐ Pending further evaluation		
☐ For any sports		
☐ For certain sports		
Reason Recommendations		
Treasure Trecommendations		
EMERGENCY INFORMATION		
Allergies		
Other information		
HCP OFFICE STAMP	SCHOOL PHYSICIAN:	
	Reviewed on	(Date)
	Approved Not	Approved
	Signature:	
	9	
I have examined the above-named student and completed the prep- clinical contraindications to practice and participate in the sport(s) and can be made available to the school at the request of the paren the physician may rescind the clearance until the problem is resolved (and parents/guardians).	as outlined above. A copy of the ts. If conditions arise after the a	e physical exam is on record in my office thlete has been cleared for participation,
(and parontorgual alano).		
Name of physician, advanced practice nurse (APN), physician assistant	(PA)	Date
Address		Phone
Signature of physician, APN, PA		
Completed Cardiac Assessment Professional Development Module		
DateSignature		
-		

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