PASCO SCHOOL DISTRICT

PREPARTICIPATION HISTORY AND PHYSICAL EXAMINATION

I UNDERSTAND THAT TOTAL FREEDOM FROM HEALTH PROBLEMS CANNOT BE GUARANTEED BY THE PHYSICIAN WHO PERFORMS THE PHYSICAL EXAM/SCREENING RECORDED ON THE REVERSE SIDE.

EXAM DATE_____ PARENT/GUARDIAN SIGNATURE X_____

NAME: _____ BIRTH DATE: _____ SCHOOL:_____

ADDRESS: _____ CITY: _____ ZIP:_____

HOME PHONE: _____ WORK PHONE: _____SPORT: _____

HISTORY

	YES	NO	
1.	☐	☐	Have you had any illness/injury recently, or do you have an illness/injury now?
2.	☐	☐	Have you had a medical problem, illness or injury since your last exam?
3.	☐	☐	Do you have any chronic or recurrent illness?
4.	☐	☐	Have you ever had any illness lasting more than a week?
5.	☐	☐	Have you ever been hospitalized overnight?
6.	☐	☐	Have you had any surgery other than tonsillectomy?
7.	☐	☐	Have you ever had any injuries requiring treatment by a physician?
8.	☐	☐	Do you have any organ missing other than tonsils (appendix, eye, kidney, testicle, etc.)?
9.	☐	☐	Are you presently taking ANY medications (including birth control pill, vitamin, aspirin, etc.)?
10.	☐	☐	Do you have ANY allergies (medicines, bees, foods, or other factors)? _____
11.	☐	☐	Have you ever had chest pain, dizziness, fainting, passing out during or after exercise?
12.	☐	☐	Do you tire more easily or quickly than your friends during exercise?
13.	☐	☐	Have you ever had any problem with your blood pressure or your heart?
14.	☐	☐	Have any close relatives had heart problems, heart attack or sudden death before they were age 50?
15.	☐	☐	Do you have any skin problems (acne, itching, rashes, etc.)?
16.	☐	☐	Have you ever had fainting, convulsions, seizures or severe dizziness?
17.	☐	☐	Do you have frequent severe headaches?
18.	☐	☐	Have you ever had a "stinger" or "burner" or pinched nerve?
19.	☐	☐	Have you ever been "knocked out" or "passed out"?
20.	☐	☐	Have you ever had a neck or head injury?
21.	☐	☐	Have you ever had heat exhaustion, heat stroke, heat cramps or similar heat-related problems?
22,	☐	☐	Have you ever had asthma, or trouble breathing, or cough during or after exercise?
23.	☐	☐	Do you wear eyeglasses, contact lenses or protective eye wear?
24.	☐	☐	Have you had any problem with your eyes or vision?
25.	☐	☐	Do you wear any dental appliance such as braces, bridge, plate, retainer?
26.	☐	☐	Have you ever had a knee injury?
27.	☐	☐	Have you ever had an ankle injury?
28.	☐	☐	Have you ever injured any other joint (shoulder, wrist, fingers, etc.)?
29.	☐	☐	Have you ever had a broken bone (fracture)?
30.	☐	☐	Have you ever had a cast, splint or had to use crutches?
31.	☐	☐	Has it been more than 5 years since your last tetanus booster shot?
32.	☐	☐	Are you worried about your weight?
33.	☐	☐	FEMALES: Have you any menstrual problems?
34.	☐	☐	Have you any medical concerns about participating in your sport?

****** ATHLETE SHOULD NOT WRITE BELOW THIS LINE ******

NEED EXAMINER'S COMMENTS ON ALL "YES" ANSWERS (REFER TO QUESTION NUMBER):

_____

_____

_____

PHYSICAL EXAMINATION/SCREENING

NAME_____ **GRADE**_____ **SCHOOL**_____

Age:_____ Pulse:_____

Height:_____ Blood Pressure:_____

Weight:_____ Visual Acuity: Left 20/_____

Right 20/_____

OPTIONAL

Urinalysis:

Body Fat %

HCT:

EST VO2 Max:

Audiometry:

NORMAL			ABNORMAL
☐	1.	Head	
☐	2.	Eyes (pupils), ENT	☐ _____
☐	3.	Teeth	☐ _____
☐	4.	Chest	☐ _____
☐	5.	Lungs	☐ _____
☐	6.	Heart	☐ _____
☐	7.	Abdomen	☐ _____
☐	8.	Hernia	☐ _____
☐	9.	Neurologic	☐ _____
☐	10.	Skin	☐ _____
☐	11.	Physical Maturity	☐ _____
☐	12.	Spine, Back	☐ _____
☐	13.	Shoulders, Upper extremities	☐ _____
☐	14.	Lower extremities	☐ _____
			☐ _____

Assessment:

☐ Full participation

☐ Limited participation (describe limitations, restrictions):

_____

_____

☐ Participation contraindicated (list reasons):

_____

_____

Recommendations (equipment, taping, rehabilitation, etc):

_____

_____

EXAMINER'S SIGNATURE:_____ **TODAYS DATE:**_____

EXAMINER'S PHONE:_____ **PRINT/STAMP EXAMINER'S NAME:**_____

Hc126 (6/00) physexam