2021-2022	
School:	North Control of the
Grade:	

PREPARTICIPATION PHYSICAL EVALUATION

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or echocardiography.

Note: Complete and sign this form (with your parent	ts if younger than 18) before your appointment. Date of birth:
Name:	
Sex assigned at birth (F, M, or intersex):	그는 그
List past and current medical conditions.	
Have you ever had surgery? If yes, list all past surgi	cal procedures.
Medicines and supplements: List all current prescrip	ptions, over-the-counter medicines, and supplements (herbal and nutritional).
Do you have any allergies? If yes, please list all you	ur allergies (ie, medicines, pollens, food, stinging insects).
Feeling nervous, anxious, or on edge Not being able to stop or control worrying Little interest or pleasure in doing things Feeling down, depressed, or hopeless	othered by any of the following problems? (check box next to appropriate number. Not at all Several days Over half the days Nearly every day. 0 1 2 3 0 1 2 3 0 1 2 3 0 1 2 3 0 1 2 3 0 1 2 3 0 1 2 3 0 3 3 0 1 2 3 0 3 4 0 5 5 5 0 5 6 0 6 7 0 7 8 0 7 9 0 9 9 0 9 9 9 0 9 9 9 0 9 9 9 0 9 9 9 0 9 9 9 0 9 9 9 0 9 9 9 0 9 9 9 0 9 9 9 0 9 9 9 0 9 9 9 0 9 9 9 0 9 9 9 0 9 9 9 0 9 9 9 0 9 9 9 0 9 9 9 0 9 9 9 0 9 9 9 0 9 9 9 0 9 9 9 0 9 9 9 0 9 9 9 0 9 9 9 0 9 9 9 0 9 9 9 0 9 9 9 0 9 9 9 0 9 9 9 0 9 9 9 0 9 9 9 0 9 9 9 0 9 9 9 0 9 9 9 0 9 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9 0 9 9
GENERAL QUESTIONS [Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.] 1. Do you have any concerns that you would like to discuss with your provider? 2. Has a provider ever denied or restricted your participation in sports for any reason? 3. Do you have any ongoing medical issues or recent illness? HEART HEALTH QUESTIONS ABOUT YOU 4. Have you ever passed out or nearly passed out during or after exercise? 5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? 6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise? 7. Has a doctor ever told you that you have any	HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED) 9. Do you get light-headed or feel shorter of breath than your friends during exercise? 10. Have you ever had a seizure? HEART HEALTH QUESTIONS ABOUT YOUR FAMILY 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)? 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)?
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG)	13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?

Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?

CINI	E AND JOINT QUESTIONS	Yes	No		MEDI	CAL QUESTIONS (CONTINUED)	Yes	No
	Have you ever had a stress fracture or an injury	State State (SEC				Do you worry about your weight?		4
	to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		L		26.	Are you trying to or has anyone recommended that you gain or lose weight?		
15.	Do you have a bone, muscle, ligament, or joint injury that bothers you?		L		The second	Are you on a special diet or do you avoid certain types of foods or food groups?		
114774110	CAL QUESTIONS	Yes	No	<u> </u>	28.	Have you ever had an eating disorder?		
	Do you cough, wheeze, or have difficulty breathing during or after exercise?				SECTION AND VALUE OF	ALES ONLY Have you ever had a menstrual period?	Yes	No
17.	Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?				30.	How old were you when you had your first menstrual period?		
18.	Do you have grain or testicle pain or a painful		II	\neg	31.	When was your most recent menstrual period?	_	
	bulge or hernia in the groin area? Do you have any recurring skin rashes or	 		卄	32.	How many periods have you had in the past 12 months?		Alter page
	rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?				Explo	ain "Yes" answers here.	7.3	
	Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?							
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?							
22.	Have you ever become ill while exercising in the heat?							
	Do you or does someone in your family have sickle cell trait or disease?	L][
	Have you ever had or do you have any prob- lems with your eyes or vision?][[-			

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School:		2021-202	22
Crado	School:		
Grade:	Grade:		

PREPARTICIPATION PHYSICAL EVALUATION

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?
 - Have you ever tried cigarettes, e-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-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: Vision: R 20/ L 20/	Corrected: Y N
MEDICAL	NORMAL ABNORMAL FINDING
Appearance Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxi myopia, mitral valve prolapse [MVP], and aortic insufficiency)	ity,
Eyes, ears, nose, and throat Pupils equal Hearing	
Lymph nodes	
Heart ^o • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)	
Lungs	
Abdomen	
 Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant Staphylococcus aureus (MRSA tinea corporis 	A), or
Neurological	
MUSCULOSKELETAL	NORMAL ABNORMAL FINDING
Neck	
Back	
Shoulder and arm	
Elbow and forearm	
Wrist, hand, and fingers	
Hip and thigh	
Knee	
Leg and ankle	
Foot and toes	
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 cardination of those. Name of health care professional (print or type):	Date:
Address:	Phone:, MD, DO, NP, c
Signature of health care professional:	, MD, DO, N,

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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 fur	ther evaluation or treatment of	
Medically eligible for certain sports		
□ Not medically eligible pending further evaluation		
□ Not medically eligible for any sports Recommendations:		
Recommendations.		
I have examined the student named on this form and completed the prep apparent clinical contraindications to practice and can participate in the examination findings are on record in my office and can be made availarise after the athlete has been cleared for participation, the physician m and the potential consequences are completely explained to the athlete (a	able to the school at the request of the parer may rescind the medical eligibility until the p and parents or guardians).	nts. If conditions roblem is resolved
Name of health care professional (print or type):		
Address:	Phone:	UD DO NIP or Pr
Signature of health care professional:		MD, DO, NP, or PA
SHARED EMERGENCY INFORMATION		
Allergies:		_
		_
Medications:		
Other information:		
Emergency contacts:		

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