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 your performance?
   • Do you wear a seat belt, use a helmet, and use condoms?

2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP</td>
<td>/</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BP</td>
<td></td>
<td></td>
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<tr>
<td>Vision</td>
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</tbody>
</table>

MEDICAL

NORMAL

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
• Murmurs (auscultation standing, supine, +/- Valsalva)
• Location of point of maximal impulse (PMI)

Pulses
• Simultaneous femoral and radial pulses

Lungs

Abdomen

Genitourinary (males only)*

Skin
• HSV, lesions suggestive of MRSA, line corporis

Neurologic†

MUSCULOSKELETAL

Neck

Back

Shoulder/arm

Elbow/forearm

Wrist/hand/fingers

Hip/thigh

Knee

Leg/ankle

Foot/toes

Functional
• Duck-walk, single leg hop

Cleared for all sports without restriction

Cleared for all sports without restriction with recommendations for further evaluation or 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 physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is 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 clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type)

Address

Signature of physician, MD or DO

**Preparticipation Physical Evaluation**

**HISTORY FORM**

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam

Name

Sex

Age

Grade

School

Sport(s)

**Medicines and Allergies:** Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking.

**Do you have any allergies?**  
☐ Yes  ☐ No  
If yes, please identify specific allergy below:  
☐ Medicines  ☐ Pollens  ☐ Food  ☐ Stinging Insects

**GENERAL QUESTIONS**

1. Has a doctor ever denied or restricted your participation in sports for any reason?  
☐ Yes  ☐ No

2. Have you ever had surgery?  
☐ Yes  ☐ No

3. Have you ever passed the night in the hospital?  
☐ Yes  ☐ No

4. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?  
☐ Yes  ☐ No

5. Do you or someone in your family have sickle cell trait or disease?  
☐ Yes  ☐ No

6. Have you ever had an unexplained seizure?  
☐ Yes  ☐ No

7. Have you ever had diarrhea or vomiting during or after exercise?  
☐ Yes  ☐ No

8. Do you or someone in your family have a heart condition?  
☐ Yes  ☐ No

9. Have you ever had a bone, muscle, or joint injury that bothers you?  
☐ Yes  ☐ No

10. Do you regularly use a brace, orthotics, or other assistive device?  
☐ Yes  ☐ No

11. Have you ever had a bone, muscle, or joint injury that bothers you?  
☐ Yes  ☐ No

12. Have you ever had a bone, muscle, or joint injury that bothers you?  
☐ Yes  ☐ No

13. Have you ever had an eating disorder?  
☐ Yes  ☐ No

14. Do you or someone in your family have sickle cell trait or disease?  
☐ Yes  ☐ No

15. Have you ever had an eating disorder?  
☐ Yes  ☐ No

16. Have you ever had an eating disorder?  
☐ Yes  ☐ No

17. Have you ever had surgery?  
☐ Yes  ☐ No

18. Have you ever had surgery?  
☐ Yes  ☐ No

19. Have you ever had surgery?  
☐ Yes  ☐ No

20. Have you ever had surgery?  
☐ Yes  ☐ No

21. Have you ever had surgery?  
☐ Yes  ☐ No

22. Have you ever had surgery?  
☐ Yes  ☐ No

23. Have you ever had surgery?  
☐ Yes  ☐ No

24. Have you ever had surgery?  
☐ Yes  ☐ No

25. Have you ever had surgery?  
☐ Yes  ☐ No

**MEDICAL QUESTIONS**

26. Have you ever had a heart murmur?  
☐ Yes  ☐ No

27. Have you ever had a heart murmur?  
☐ Yes  ☐ No

28. Have you ever had a heart murmur?  
☐ Yes  ☐ No

29. Have you ever had a heart murmur?  
☐ Yes  ☐ No

30. Have you ever had a heart murmur?  
☐ Yes  ☐ No

31. Have you ever had a heart murmur?  
☐ Yes  ☐ No

32. Have you ever had a heart murmur?  
☐ Yes  ☐ No

33. Have you ever had a heart murmur?  
☐ Yes  ☐ No

34. Have you ever had a heart murmur?  
☐ Yes  ☐ No

35. Have you ever had a heart murmur?  
☐ Yes  ☐ No

36. Have you ever had a heart murmur?  
☐ Yes  ☐ No

37. Have you ever had a heart murmur?  
☐ Yes  ☐ No

38. Have you ever had a heart murmur?  
☐ Yes  ☐ No

39. Have you ever had a heart murmur?  
☐ Yes  ☐ No

40. Have you ever had a heart murmur?  
☐ Yes  ☐ No

41. Have you ever had a heart murmur?  
☐ Yes  ☐ No

42. Have you ever had a heart murmur?  
☐ Yes  ☐ No

43. Have you ever had a heart murmur?  
☐ Yes  ☐ No

44. Have you ever had a heart murmur?  
☐ Yes  ☐ No

45. Have you ever had a heart murmur?  
☐ Yes  ☐ No

46. Have you ever had a heart murmur?  
☐ Yes  ☐ No

47. Have you ever had a heart murmur?  
☐ Yes  ☐ No

48. Have you ever had a heart murmur?  
☐ Yes  ☐ No

49. Have you ever had a heart murmur?  
☐ Yes  ☐ No

50. Have you ever had a heart murmur?  
☐ Yes  ☐ No

51. Have you ever had a heart murmur?  
☐ Yes  ☐ No

52. Have you ever had a heart murmur?  
☐ Yes  ☐ No

53. Have you ever had a heart murmur?  
☐ Yes  ☐ No

54. Have you ever had a heart murmur?  
☐ Yes  ☐ No

**I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.**

Signature of athlete

Signature of parent/guardian

Date
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 evaluation or 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 physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is 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 clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) __________________________________________ Date __________

Address __________________________________________ Phone __________

Signature of physician __________________________________________, MD or DO

EMERGENCY INFORMATION

Allergies ____________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Other information ______________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

# Preparticipation Physical Evaluation

**THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM**

Date of Exam _____________________________________________________________________________________________________________

Name ____________________________________________________________________________________________ Date of birth ____________________________

Sex _______ Age __________ Grade ______________ School ___________________________ Sport(s) _______________________

1. Type of disability
2. Date of disability
3. Classification (if available)
4. Cause of disability (birth, disease, accident/trauma, other)
5. List the sports you are interested in playing

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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6. Do you regularly use a brace, 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?  
9. Do you have a hearing loss? Do you use a hearing aid?  
10. Do you have a visual impairment?  
11. Do you use any special devices for bowel or bladder function?  
12. Do you have burning or discomfort when urinating?  
13. Have you had autonomic dysreflexia?  
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?  
15. Do you have muscle spasticity?  
16. Do you have frequent seizures that cannot be controlled by medication?

Explain “yes” answers here

---

Please indicate if you have ever had any of the following.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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</table>

Atlantoaxial instability  
X-ray evaluation for atlantoaxial instability  
Dislocated joints (more than one)  
Easy bleeding  
Enlarged spleen  
Hepatitis  
Osteopenia or osteoporosis  
Difficulty controlling bowel  
Difficulty controlling bladder  
Numbness or tingling in arms or hands  
Numbness or tingling in legs or feet  
Weakness in arms or hands  
Weakness in legs or feet  
Recent change in coordination  
Recent change in ability to walk  
Spina bifida  
Latex allergy

Explain “yes” answers here

---

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

Signature of athlete __________________________ Signature of parent/guardian __________________________ Date ___________