

SOUTHERN CHRISTIAN ATHLETICS
Preparticipation Physical Evaluation Form

History Date _____
 Name _____ Sex _____ Age _____ Date of birth _____
 Address _____ Phone _____
 School _____ Grade _____ Sport _____

Explain "Yes" answers below:	Yes	No
1. Has a doctor ever restricted/denied your participation in sports?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized or spent a night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>
Have ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have any ongoing medical conditions (like Diabetes or Asthma)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you presently taking any medications or pills (prescription or over-the-counter)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any allergies (medicine, pollens, foods, bees or other stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had chest pain or discomfort in your chest during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Do you tire more quickly than your friends during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been told that you have a heart murmur, high cholesterol, or heart infection?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone in your family died of heart problems or a sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>
Does anyone in your family have a heart condition?	<input type="checkbox"/>	<input type="checkbox"/>
Has a doctor ever ordered a test on your heart (EKG, echocardiogram)?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have any skin problems (itching, rashes, staph, MRSA, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been knocked out or unconscious?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a stinger, burner, pinched nerve, or loss of feeling or weakness in your arms or legs?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever had heat or muscle cramps?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been dizzy or passed out in the heat?	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have trouble breathing or do you cough during or after activity?	<input type="checkbox"/>	<input type="checkbox"/>
Do you take any medications for asthma (for instance, inhalers)?	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear glasses or contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you had any other medical problems (infectious mononucleosis, diabetes, infectious diseases, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you had a medical problem or injury since your last evaluation?	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you ever been told you have sickle cell trait?	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone in your family had sickle cell disease or sickle cell trait?	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Head <input type="checkbox"/> Back <input type="checkbox"/> Shoulder <input type="checkbox"/> Forearm <input type="checkbox"/> Hand <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Ankle		
<input type="checkbox"/> Neck <input type="checkbox"/> Chest <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Finger <input type="checkbox"/> Thigh <input type="checkbox"/> Shin <input type="checkbox"/> Foot		
17. When was your first menstrual period? _____		
When was your last menstrual period? _____		
What was the longest time between your periods last year? _____		
Explain "Yes" answers:		

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

Signature of athlete _____ Date _____

Signature of parent/guardian _____

Preparticipation Physical Evaluation

Student's name _____

Physical Examination

LIMITED	Height _____ Weight _____ BP _____ / _____ Pulse _____	
	Vision R 20 / _____ L 20 / _____ Corrected: Y N	
	Normal	Abnormal Findings
Cardiovascular		
Pulses		
Heart		
Lungs		
Skin		
E.N.T.		
Abdominal		
Genitalia (males)		
Musculoskeletal		
Neck		
Shoulder		
Elbow		
Wrist		
Hand		
Back		
Knee		
Ankle		
Foot		
Other		

Clearance:

A. Cleared

B. Cleared after completing evaluation/rehabilitation for: _____

C. Not cleared for:

Collision

Contact

Noncontact

____ Strenuous

____ Moderately Strenuous

____ Nonstrenuous

Due to: _____

Recommendation: _____

Name of physician _____ Date _____

Address _____ Phone _____

Signature of physician _____, M.D. or D.O.

(Form must be signed and dated by the attending physician.)