



**ANNUAL PREPARTICIPATION PHYSICAL EVALUATION**

(The Parent or Guardian should fill out this form with assistance from the student athlete.)

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

In case of emergency, contact: Name: \_\_\_\_\_

Explain "Yes" answers below. Phone (H): \_\_\_\_\_ (W) \_\_\_\_\_  
 Circle questions you don't know the answer to. Cell Phone: \_\_\_\_\_

	Yes	No		Yes	No
1. Have you had a medical illness or injury since your last check-up or sports physical?	<input type="radio"/>	<input type="radio"/>	9. Do you cough, wheeze, or have trouble breathing during or after activity?	<input type="radio"/>	<input type="radio"/>
Do you have an ongoing or chronic illness?	<input type="radio"/>	<input type="radio"/>	Do you have asthma?	<input type="radio"/>	<input type="radio"/>
Are you currently being treated for an injury or condition?	<input type="radio"/>	<input type="radio"/>	Do you use an inhaler?	<input type="radio"/>	<input type="radio"/>
_____			Do you have seasonal allergies that require medical treatment?	<input type="radio"/>	<input type="radio"/>
2. Have you ever been hospitalized overnight?	<input type="radio"/>	<input type="radio"/>	10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	<input type="radio"/>	<input type="radio"/>
Have you ever had surgery?	<input type="radio"/>	<input type="radio"/>	_____		
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?	<input type="radio"/>	<input type="radio"/>	11. Have you had any problems with your eyes or vision?	<input type="radio"/>	<input type="radio"/>
_____			Do you wear glasses, contacts, or protective eyewear?	<input type="radio"/>	<input type="radio"/>
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	<input type="radio"/>	<input type="radio"/>	12. Have you ever had a sprain, strain, or swelling after injury?	<input type="radio"/>	<input type="radio"/>
_____			Have you broken or fractured any bones or dislocated any joints?	<input type="radio"/>	<input type="radio"/>
4. Do you have any allergies to medications?	<input type="radio"/>	<input type="radio"/>	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	<input type="radio"/>	<input type="radio"/>
Do you have any allergies to pollen, food or stinging insects?	<input type="radio"/>	<input type="radio"/>			
_____					
Have you ever had a rash or hives develop during or after exercise?	<input type="radio"/>	<input type="radio"/>			
5. Have you ever passed out during or after exercise?	<input type="radio"/>	<input type="radio"/>			
Have you ever been dizzy during or after exercise?	<input type="radio"/>	<input type="radio"/>			
Have you ever had chest pain during or after exercise?	<input type="radio"/>	<input type="radio"/>			
Do you get tired more quickly than your friends during exercise?	<input type="radio"/>	<input type="radio"/>			
Have you ever had racing of your heart or skipped heartbeats?	<input type="radio"/>	<input type="radio"/>			
Have you had high blood pressure or high cholesterol?	<input type="radio"/>	<input type="radio"/>			
Have you ever been told you have a heart murmur?	<input type="radio"/>	<input type="radio"/>			
Have you had a severe viral infection (i.e., mononucleosis or myocarditis) within the last month?	<input type="radio"/>	<input type="radio"/>			
Has a doctor ever denied or restricted your participation in sports for any heart problems?	<input type="radio"/>	<input type="radio"/>			
Has anyone in your immediate family had the following conditions?	<input type="radio"/>	<input type="radio"/>			
Diabetes _____ Heart disease _____ other _____					
Sudden death prior to age 50 _____ High Blood Pressure _____					
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	<input type="radio"/>	<input type="radio"/>			
7. Have you ever had a head injury or concussion?	<input type="radio"/>	<input type="radio"/>			
Have you ever been knocked out, become unconscious, or lost your memory?	<input type="radio"/>	<input type="radio"/>			
Have you ever had a seizure?	<input type="radio"/>	<input type="radio"/>			
Do you have frequent or severe headaches?	<input type="radio"/>	<input type="radio"/>			
Have you ever had numbness or tingling in your arms, hands, legs, or feet?	<input type="radio"/>	<input type="radio"/>			
Have you ever had a stinger, burner, or pinched nerve?	<input type="radio"/>	<input type="radio"/>			
8. Have you ever become ill from exercising in the heat?	<input type="radio"/>	<input type="radio"/>			

- If yes, check appropriate box below.**
- |                                 |                               |                                 |
|---------------------------------|-------------------------------|---------------------------------|
| <input type="radio"/> Head      | <input type="radio"/> Elbow   | <input type="radio"/> Hip       |
| <input type="radio"/> Neck      | <input type="radio"/> Forearm | <input type="radio"/> Thigh     |
| <input type="radio"/> Back      | <input type="radio"/> Wrist   | <input type="radio"/> Knee      |
| <input type="radio"/> Chest     | <input type="radio"/> Hand    | <input type="radio"/> Shin/calf |
| <input type="radio"/> Shoulder  | <input type="radio"/> Finger  | <input type="radio"/> Ankle     |
| <input type="radio"/> Upper arm |                               | <input type="radio"/> Foot      |

13. Do you want to weigh more or less than you do now?  
 Do you lose weight regularly to meet weight requirements for your sport?  Yes  No
14. Do you feel stressed?  Yes  No
15. Do you or have you ever used:  
 Smokeless tobacco \_\_\_\_\_ Cigarettes \_\_\_\_\_  
 Alcohol \_\_\_\_\_ Recreational drugs \_\_\_\_\_

**Females Only**

16. When was your first menstrual period? \_\_\_\_\_  
 When was your most recent menstrual period? \_\_\_\_\_  
 How much time do you usually have from the start of one period to the start of another? \_\_\_\_\_  
 How many periods have you had in the last year? \_\_\_\_\_  
 What was the longest time between periods in the last year? \_\_\_\_\_

Explanation: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.  
 I understand and acknowledge that truthful and accurate information is essential in properly determining whether the student should be cleared for athletic participation.  
 I hereby consent for the student named above, to be given medical care by the doctor selected by the school.

Signature of Parent/Guardian \_\_\_\_\_ Signature of Student Athlete \_\_\_\_\_ Date \_\_\_\_\_  
 FORM 15.7-A 6/05