

# Preparticipation Physical Evaluation

HISTORY \_\_\_\_\_

DATE OF EXAM \_\_\_\_\_

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_  
 Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_  
 Personal physician \_\_\_\_\_  
**In case of emergency, contact**  
 Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_

Explain "Yes" answers below.  
 Circle questions you don't know the answers to.

- |  |  |                                    |                                |                              |                               |                                  |                                |                               |                                |                               |                                |                               |                                    |                                   |                                 |                                |                                    |  |                               |
|--|--|------------------------------------|--------------------------------|------------------------------|-------------------------------|----------------------------------|--------------------------------|-------------------------------|--------------------------------|-------------------------------|--------------------------------|-------------------------------|------------------------------------|-----------------------------------|---------------------------------|--------------------------------|------------------------------------|--|-------------------------------|
| <p>1. Have you had a medical illness or injury since your last check up or sports physical?<br/>                 Do you have an ongoing or chronic illness? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Have you ever been hospitalized overnight?<br/>                 Have you ever had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?<br/>                 Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?<br/>                 Have you ever had a rash or hives develop during or after exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Have you ever passed out during or after exercise?<br/>                 Have you ever been dizzy during or after exercise?<br/>                 Have you ever had chest pain during or after exercise?<br/>                 Do you get tired more quickly than your friends do during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>                 Have you ever had racing of your heart or skipped heartbeats? <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>                 Have you had high blood pressure or high cholesterol?<br/>                 Have you ever been told you have a heart murmur?<br/>                 Has any family member or relative died of heart problems or of sudden death before age 50?<br/>                 Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?<br/>                 Has a physician ever denied or restricted your participation in sports for any heart problems? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Have you ever had a head injury or concussion?<br/>                 Have you ever been knocked out, become unconscious, or lost your memory? <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>                 Have you ever had a seizure? <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>                 Do you have frequent or severe headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>                 Have you ever had numbness or tingling in your arms, hands, legs, or feet? <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>                 Have you ever had a stinger, burner, or pinched nerve? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Have you ever become ill from exercising in the heat? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Do you cough, wheeze, or have trouble breathing during or after activity? <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>                 Do you have asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>                 Do you have seasonal allergies that require medical treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>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="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Have you had any problems with your eyes or vision?<br/>                 Do you wear glasses, contacts, or protective eyewear? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Have you ever had a sprain, strain, or swelling after injury?<br/>                 Have you broken or fractured any bones or dislocated any joints? <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>                 Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?<br/> <i>If yes, check appropriate box and explain below</i></p> <table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> Head</td> <td><input type="checkbox"/> Elbow</td> <td><input type="checkbox"/> Hip</td> </tr> <tr> <td><input type="checkbox"/> Neck</td> <td><input type="checkbox"/> Forearm</td> <td><input type="checkbox"/> Thigh</td> </tr> <tr> <td><input type="checkbox"/> Back</td> <td><input type="checkbox"/> Wrist</td> <td><input type="checkbox"/> Knee</td> </tr> <tr> <td><input type="checkbox"/> Chest</td> <td><input type="checkbox"/> Hand</td> <td><input type="checkbox"/> Shin/calf</td> </tr> <tr> <td><input type="checkbox"/> Shoulder</td> <td><input type="checkbox"/> Finger</td> <td><input type="checkbox"/> Ankle</td> </tr> <tr> <td><input type="checkbox"/> Upper arm</td> <td></td> <td><input type="checkbox"/> Foot</td> </tr> </table> <p>13. Do you want to weigh more or less than you do now?<br/>                 Do you lose weight regularly to meet weight requirements for your sport? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. Do you feel stressed out? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>15. Record the dates of your most recent immunizations (shots) for:<br/>                 Tetanus _____ Measles _____<br/>                 Hepatitis B _____ Chickenpox _____</p> <p><b>FEMALES ONLY</b></p> <p>16. When was your first menstrual period? _____<br/>                 When was your most recent menstrual period? _____<br/>                 How much time do you usually have from the start of one period to the start of another? _____<br/>                 How many periods have you had in the last year*? _____<br/>                 What was the longest time between periods in the last year? _____<br/>                 Explain "Yes" answers here:<br/>                 _____<br/>                 _____<br/>                 _____<br/>                 _____</p> | <input type="checkbox"/> Head      | <input type="checkbox"/> Elbow | <input type="checkbox"/> Hip | <input type="checkbox"/> Neck | <input type="checkbox"/> Forearm | <input type="checkbox"/> Thigh | <input type="checkbox"/> Back | <input type="checkbox"/> Wrist | <input type="checkbox"/> Knee | <input type="checkbox"/> Chest | <input type="checkbox"/> Hand | <input type="checkbox"/> Shin/calf | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Finger | <input type="checkbox"/> Ankle | <input type="checkbox"/> Upper arm |  | <input type="checkbox"/> Foot |
| <input type="checkbox"/> Head  | <input type="checkbox"/> Elbow   | <input type="checkbox"/> Hip       |                                |                              |                               |                                  |                                |                               |                                |                               |                                |                               |                                    |                                   |                                 |                                |                                    |  |                               |
| <input type="checkbox"/> Neck  | <input type="checkbox"/> Forearm   | <input type="checkbox"/> Thigh     |                                |                              |                               |                                  |                                |                               |                                |                               |                                |                               |                                    |                                   |                                 |                                |                                    |  |                               |
| <input type="checkbox"/> Back  | <input type="checkbox"/> Wrist   | <input type="checkbox"/> Knee      |                                |                              |                               |                                  |                                |                               |                                |                               |                                |                               |                                    |                                   |                                 |                                |                                    |  |                               |
| <input type="checkbox"/> Chest   | <input type="checkbox"/> Hand  | <input type="checkbox"/> Shin/calf |                                |                              |                               |                                  |                                |                               |                                |                               |                                |                               |                                    |                                   |                                 |                                |                                    |  |                               |
| <input type="checkbox"/> Shoulder  | <input type="checkbox"/> Finger  | <input type="checkbox"/> Ankle     |                                |                              |                               |                                  |                                |                               |                                |                               |                                |                               |                                    |                                   |                                 |                                |                                    |  |                               |
| <input type="checkbox"/> Upper arm   |  | <input type="checkbox"/> Foot      |                                |                              |                               |                                  |                                |                               |                                |                               |                                |                               |                                    |                                   |                                 |                                |                                    |  |                               |

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 \_\_\_\_\_

© 1997 American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

# Preparticipation Physical Evaluation

## PHYSICAL EXAMINATION

Name _____		Date of birth _____	
Height _____	Weight _____	% Body fat (optional) _____	Pulse _____ BP _____/_____/_____
Vision R 20/ _____	L 20/ _____	Corrected: Y N	Pupils: Equal _____ Unequal _____

			INITIALS*
<b>MEDICAL</b>			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
<b>MUSCULOSKELETAL</b>			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip (thigh)			
Knee			
Leg/ankle			
Foot			

\*Station-based examination only

## CLEARANCE

Cleared

Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_

Not cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_

Recommendations: \_\_\_\_\_

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

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

Signature of physician \_\_\_\_\_, MD, Do, PAC, RNP, or DC

© 1997 American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

**STEAMBOAT SPRINGS SCHOOL DIST. RE-2**  
**325 7<sup>th</sup> Street**  
**Steamboat Springs, CO 80487**  
**970-879-1058**

**STEAMBOAT SPRINGS MIDDLE SCHOOL**

**AUTHORIZATION FOR ATHLETIC PARTICIPATION**

**PLEASE PRINT**

Grade (circle)

Name: (Last, First, M.I.) \_\_\_\_\_ 7 8

Address: \_\_\_\_\_

Name of Parent/Legal Guardian: \_\_\_\_\_

**PHYSICIAN'S STATEMENT**

"I certify that I have on this date examined this student and that, on the basis of this examination and the student's medical history as furnished to me, I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities, except for those crossed out below."

Basketball

Track

Cross-Country

Volleyball

Football

Wrestling

Date of Examination: \_\_\_\_\_

Signed: \_\_\_\_\_ MD

Date: \_\_\_\_\_ Phone: \_\_\_\_\_

## **PARENT OR LEGAL GUARDIAN PERMISSION**

By its nature, participation in interscholastic athletics includes risk of injury which may range in severity from minor to disabling to even death. Although serious injuries are not common in supervised school athletic programs, it is impossible to eliminate the risk. Participants can and have the responsibility to help reduce the chances of injury. Players must obey all safety rules, report all physical problems to their coaches, follow a proper conditioning program and inspect their own equipment daily.

By signing this Permission Form, we acknowledge that we have read the above information. **PARENTS OR STUDENTS WHO DO NOT WISH TO ACCEPT THE RISK DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS PERMISSION FORM**

### **I hereby give my consent for the above named student:**

1. To represent his/her school in approved athletic activities except those crossed out in this booklet by the examining medical doctor.
2. To accompany any school team of which he/she is a member on its out-of-town trips. The athletes will be transported to and from all events on school district vehicles. Parents wishing to have their students ride with them when returning from an event must make arrangements with the coach in charge.
3. To receive, through a medical doctor of the school's choice, emergency medical care which may become reasonably necessary in the course of such athletic activities or such travel.

I further agree not to hold the school or anyone acting in its behalf responsible for any injury occurring to the above named student in the proper course of such athletic activities or travel.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
**parent/legal guardian**

I have read the foregoing and will abide by the principles and regulations contained therein.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
**student**

## **ATHLETIC INSURANCE WAIVER**

I fully understand that the Steamboat Springs School District does not provide any accident or health insurance coverage for my son/daughter while participating in interscholastic athletics. I fully understand that I must provide insurance coverage for my son/daughter.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
**parent/legal guardian**

My son/daughter is presently covered under a policy issued by:

\_\_\_\_\_  
**(Insurance Company)**

**Signature:** \_\_\_\_\_

I wish to enroll my son/daughter in a supplemental insurance program offered by an insurance company authorized by Steamboat Springs School District.

**Signature:** \_\_\_\_\_

### **NOTE:**

**THIS FORM MUST BE COMPLETED IN ALL DETAIL AND FILED IN THE OFFICE OF THE PRINCIPAL BEFORE THE STUDENT WILL BE ALLOWED TO PRACTICE OR COMPETE IN ATHLETICS.**