Athletic Pre-Participation History and Physical Examination

(Must have a current exam on file that lasts the duration of the sport you will be playing)

Name: _____ Birthdate: _____ Exam Date: _____
Address: _____ CITY: _____ ZIP: _____
Phone: _____ Gender: ☐ Male ☐ Female Sport: _____

	Yes	No	History
1.	☐	☐	Have you had any illness/injury recently, or do you have an illness/injury now?
	☐	☐	Have you had a medical problem, illness, or injury since your last exam?
	☐	☐	Do you have any chronic or recurrent illness?
	☐	☐	Have you ever had any illness lasting more than a week?
	☐	☐	Have you ever been hospitalized overnight?
	☐	☐	Have you had any surgery other than tonsillectomy?
	☐	☐	Have you ever had any injuries requiring treatment by a physician?
	☐	☐	Do you have any organ missing other than tonsils (appendix, eye, kidney, testicle, etc.)?
2.	☐	☐	Are you presently taking ANY medications (including birth control pill, vitamin, aspirin, etc.)?
3.	☐	☐	Do you have ANY allergies (medicines, bees, foods, or other factors)?
4.	☐	☐	Have you ever had chest pain, dizziness, fainting, passing out during or after exercise?
	☐	☐	Do you tire more easily or quickly than your friends during exercise?
	☐	☐	Have you ever had any problem with your blood pressure or your heart?
	☐	☐	Have any close relatives had heart problems, heart attack, or sudden death before age 50?
5.	☐	☐	Do you have any skin problems (acne, itching, rashes, etc.)?
6.	☐	☐	Have you ever had fainting, convulsions, seizures, or severe dizziness?
	☐	☐	Do you have frequent severe headaches?
	☐	☐	Have you ever had a “stinger” or “burner” or “pinched nerve?”
	☐	☐	Have you ever been “knocked out” or “passed out?”
	☐	☐	Have you ever had a neck or head injury?
7.	☐	☐	Have you ever had heat exhaustion, heat stroke, heat cramps, or any heat-related problems?
8.	☐	☐	Have you had asthma, or trouble breathing, or cough during or after exercise?
9.	☐	☐	Do you wear eyeglasses, contact lenses, or protective eye wear?
	☐	☐	Have you had any problem with your eyes or vision?
10.	☐	☐	Do you wear any dental appliance such as braces, bridge, plate, retainer?
11.	☐	☐	Have you ever had a knee injury?
	☐	☐	Have you ever had an ankle injury?
	☐	☐	Have you ever injured any other joint (shoulder, wrist, fingers, etc.)?
	☐	☐	Have you ever had a broken bone (fracture)?
	☐	☐	Have you ever had a cast, splint, or had to use crutches?
	☐	☐	Must you use special equipment for competition (pads, braces, neck roll, etc.)?
12.	☐	☐	Has it been more than 5 years since your last tetanus booster shot?
13.	☐	☐	Are you worried about your weight?
14.	☐	☐	FEMALES: Do you have any menstrual problems?
15.	☐	☐	Do you have any medical concerns about participating in your sport?

Parents/Athletes – Do Not Write Below This Line

Examiner’s Comments on all “YES” Answers (Refer to question number):
_____
_____
_____
_____
_____
_____

Prior to the first practice for participation in interscholastic athletics a student shall undergo a thorough medical examination and be approved for athletic competition by a medical authority licensed to perform a physical examination. Licensed medical authorities refer to the following: Medical Doctor (MD), Doctor of Osteopathy (DO), Advanced Registered Nurse Practitioner (ARNP), Physician’s Assistant (PA) or Naturopathic Physician. \The physical examination shall be valid for twenty-four (24) consecutive months.

Physical Examination

Student Name: _____ Age: _____ Height: _____ Weight: _____
Pulse: _____ Blood Pressure: _____ Visual Acuity: Left: 20/_____ Right: 20/_____

Postural/Alignment
❒ WNL ❒ Concerns:_____

Flexibility/ROM (Key: Check **WNL** = Within Normal Limit *or* **R** = Restricted (& specify))

Behind Back Scratch (UE)	❒ WNL	❒ R: _____	LSP	❒ WNL	❒ R: _____
Climber (LE)	❒ WNL	❒ R: _____	CSP	❒ WNL	❒ R: _____
Squat (LE)	❒ WNL	❒ R: _____			

Comments:

Strength Testing

Functional Tests

Squat (10x)	R: _____	L: _____	Fwd Lunge (10x):	R: _____ L: _____
Heel Raise (10x)	R: _____	L: _____	Push-ups (10x):	_____
Hop Test (10x)	R: _____	L: _____	Sit Up/Crunch (10x):	_____

Use below if functional tests exhibit area of concern

Neck:			**Hip:**			**Ankle:**			**Shoulder:**		
Flexion		____	Flex	R	L	Dorsi Flex	R	L	Flex	R	L
Extension			Ext	R	L	Plant. Flex	R	L	Ext	R	L
Rotation			IR	R	L	Inversion	R	L	Add	R	L
Side Bending			ER	R	L	Eversion	R	L	Adb	R	L
Elbow:			Abd	R	L	**Knee:**			IR	R	L
Flexion	R	L	Add	R	L	Flex	R	L	ER	R	L
Extension	R	L	**Abdominal:**			Ext	R	L	**Back:**		
			Sit Up	_____					Extension		

Comments:

Date: _____ *Examiner's Signature:* _____

Medical Screen (Key: Check **WNL** = Within Normal Limit *or* **Abnormal**. Comment on abnormal findings)

Head	❒ WNL	❒ Abnormal	Lung	❒ WNL	❒ Abnormal	Neurologic	❒ WNL	❒ Abnormal
Eyes	❒ WNL	❒ Abnormal	Heart	❒ WNL	❒ Abnormal	Skin	❒ WNL	❒ Abnormal
ENT	❒ WNL	❒ Abnormal	Spine/Back	❒ WNL	❒ Abnormal	Phys Maturity	❒ WNL	❒ Abnormal
Teeth	❒ WNL	❒ Abnormal	Shld/UE	❒ WNL	❒ Abnormal	LE	❒ WNL	❒ Abnormal
Chest	❒ WNL	❒ Abnormal	Genitalia	❒ WNL	❒ Abnormal			

ASSESSMENT
❒ Full Participation ❒ Limited Participation (*Describe*) ❒ Participation Contraindicated (*list*)

Date: _____
Examiner's Phone: _____
Examiner's Signature: _____
Print Examiner's Name: _____
Health concerns information may be shared with school personnel as necessary to benefit the safety of District students and others. (Please keep information updated)

Physician/Clinic Stamp

Per WIAA the following is the list of authorized licensed health care providers: Medical Doctors; Doctor of Osteopathy; Advanced Registered Nurse Practitioner; Physician's Assistant; Licensed Certified Athletic Trainers