

# High School Athletic Association Preparticipation Physical Examination Form

(Please type or print)

Student's Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex \_\_\_\_\_ Grade \_\_\_\_\_

Last First Middle

City \_\_\_\_\_ School \_\_\_\_\_ Place of Birth \_\_\_\_\_

Student's Address \_\_\_\_\_

Street City Zip Telephone

Parent(s) or Guardian(s) Name \_\_\_\_\_

Address (if different than student) \_\_\_\_\_

Street City Zip Telephone

Family Physician's Name, Address, Telephone \_\_\_\_\_

## History

This section is to be carefully completed by the student and his/her parent(s) or legal guardian(s) before participation in interscholastic athletics in order to help detect possible risks.

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

	Yes	No		Yes	No																				
<b>1.</b> Have you had a medical illness or injury since your last checkup or sports physical? Do you have an ongoing or chronic illness?	<input type="checkbox"/>	<input type="checkbox"/>	<b>10.</b> Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>																				
<b>2.</b> Have you ever been hospitalized overnight? Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<b>11.</b> Do you cough, wheeze or have trouble breathing during or after activity? Do you have asthma? Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>																				
<b>3.</b> Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler? Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	<input type="checkbox"/>	<input type="checkbox"/>	<b>12.</b> 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"/>	<input type="checkbox"/>																				
<b>4.</b> Do you think you are in good health?	<input type="checkbox"/>	<input type="checkbox"/>	<b>13.</b> Have you had any problems with your eyes or vision? Do you wear glasses, contacts or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>																				
<b>5.</b> Do you have any allergies (for example, to pollen, medicine, food, or stinging insect)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>14.</b> Have you ever had a sprain, strain or swelling after injury? Have you broken or fractured any bones or dislocated any joints? Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? <i>If yes, check the appropriate box and explain below.</i>	<input type="checkbox"/>	<input type="checkbox"/>																				
<b>6.</b> Have you ever had a rash or hives develop during or after exercise? Have you ever passed out during or after exercise? Have you ever been dizzy during or after exercise? Have you ever had chest pain during or after exercise? Do you get tired more quickly than your friends do during exercise? Have you ever had racing of your heart or skipped heartbeats? Have you had high blood pressure or high cholesterol? Have you ever been told you have a heart murmur? Has any family member or relative died of heart problems or of sudden death before age 50? Is there a family history of heart problems in a close relative younger than age 50 (examples are enlarged heart, cardiomyopathy, long QT interval, abnormal EKG, abnormal heart rhythm)?	<input type="checkbox"/>	<input type="checkbox"/>	<table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> Head</td> <td><input type="checkbox"/> Upper Arm</td> <td><input type="checkbox"/> Hand</td> <td><input type="checkbox"/> Knee</td> </tr> <tr> <td><input type="checkbox"/> Neck</td> <td><input type="checkbox"/> Elbow</td> <td><input type="checkbox"/> Finger</td> <td><input type="checkbox"/> Shin/calf</td> </tr> <tr> <td><input type="checkbox"/> Back</td> <td><input type="checkbox"/> Forearm</td> <td><input type="checkbox"/> Hip</td> <td><input type="checkbox"/> Ankle</td> </tr> <tr> <td><input type="checkbox"/> Chest</td> <td><input type="checkbox"/> Wrist</td> <td><input type="checkbox"/> Thigh</td> <td><input type="checkbox"/> Foot</td> </tr> <tr> <td><input type="checkbox"/> Shoulder</td> <td colspan="3"></td> </tr> </table>	<input type="checkbox"/> Head	<input type="checkbox"/> Upper Arm	<input type="checkbox"/> Hand	<input type="checkbox"/> Knee	<input type="checkbox"/> Neck	<input type="checkbox"/> Elbow	<input type="checkbox"/> Finger	<input type="checkbox"/> Shin/calf	<input type="checkbox"/> Back	<input type="checkbox"/> Forearm	<input type="checkbox"/> Hip	<input type="checkbox"/> Ankle	<input type="checkbox"/> Chest	<input type="checkbox"/> Wrist	<input type="checkbox"/> Thigh	<input type="checkbox"/> Foot	<input type="checkbox"/> Shoulder				<input type="checkbox"/>	<input type="checkbox"/>
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Have you ever had a severe heart infarction (for example, myocarditis or pericarditis)? Is there a family history of Marfan's Syndrome? Has a physician ever denied or restricted your participation in sports for any heart problem?	<input type="checkbox"/>	<input type="checkbox"/>	<b>15.</b> Do you want to weigh more or less than you do now? Do you lose weight regularly to meet weight requirements for your sport?	<input type="checkbox"/>	<input type="checkbox"/>																				
<b>7.</b> Have you ever had a severe viral infection within the last month (for example, mononucleosis)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>16.</b> Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>																				
<b>8.</b> Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>17.</b> Record the dates of your most recent immunizations (shots) for: Tetanus _____ Measles _____ Hepatitis B _____ Chickenpox _____																						
<b>9.</b> Have you ever had a head injury or concussion? Have you ever been knocked out, become unconscious or lost your memory? Have you ever had a seizure? Do you have frequent or severe headaches? Have you ever had numbness or tingling in your arms, hands, legs or feet? Have you ever had a stinger, burner or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	<b>18. FEMALES ONLY</b> 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? _____																						
	<input type="checkbox"/>	<input type="checkbox"/>	<b>19. ALL PARTICIPANTS</b> Explain "Yes" answers here: _____ _____ _____ _____ _____																						

We consent to the participation of the above-named student in the interscholastic program of his/her school including practice sessions and travel to and from athletic contests. We also agree to emergency medical treatment as deemed necessary by the physician(s) designated school authorities. We have read and understand the HSA Athletic Eligibility Information Bulletin.

Student Signature \_\_\_\_\_ Parent or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

The student has family insurance \_\_\_ Yes \_\_\_ No; If yes, family insurance co. name, policy #: \_\_\_\_\_

**NOTE: History and Consent Must be Completed Prior to Physical Examination**

Modified from the form approved by the American Academy of Family Physicians, the American Academy of Pediatrics, the American Medical Society for Sports Medicine, the American Orthopaedic Society for Sports Medicine and the American Osteopathic Academy of Sports Medicine.

# Physical Examination

(Please type or print)

Student's Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
Last First Middle

Height \_\_\_\_\_ Weight \_\_\_\_\_ % Body Fat (optional) \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_/\_\_\_\_\_

Vision R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ Corrected: Y N Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

**Normal**

**Abnormal Findings**

**Initials\***

## MEDICAL

	Normal	Abnormal Findings	Initials*
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			

## MUSCULOSKELETAL

	Normal	Abnormal Findings	Initials*
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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I certify that I have on this date examined this student and that, on the basis of the examination requested by the school authorities 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 (Note exceptions above).

Physician's Name and Address (stamp or print) \_\_\_\_\_  
 If the Physician's Assistant (P.A.) or Advanced Nurse Practitioner (A.N.P.) performed the exam, name and address of collaborating physician or physician group: \_\_\_\_\_

Examiner's Signature \_\_\_\_\_ Date \_\_\_\_\_

Examiner's Telephone Number \_\_\_\_\_

**NOTE: History and Consent Must be Completed Prior to Physical Examination**

