The pre-participation physical examination is not a substitute for a thorough annual examination by a student's primary care physician

| PART II MEDICAL HISTORY- Explain "Yes" answers below   |     |     |   |          |              |  |  |  |
|--|-----|-----|---|----------|--------------|--|--|--|
| This form must be completed and signed, prior to the physical examination, for review by examining practitioner.   |     |     |   |          |              |  |  |  |
| Explain "Yes" answers below with number of the question. Circle questions you don't know the answers to.   |     |     |   |          |              |  |  |  |
| GENERAL MEDICAL HISTORY  | Yes | No  | MEDICAL QUESTIONS (cont)  | Yes      | No           |  |  |  |
| Has a doctor ever denied or restricted your participation in sports for any reason?  |     |     | 29. Do you have groin pain or a painful bulge or hernia in<br>the groin area?                                 |          |              |  |  |  |
| 2. Do you currently have an ongoing medical condition? If so,  |     |     | the grown weat.   | 1        | <del> </del> |  |  |  |
| Please identify: Asthma Anemia Diabetes  |     |     | 30. Have you had mononucleosis (mono) within the last   |          |              |  |  |  |
| Infections Other:  3. Have you ever spent the night in the hospital?   | -   | -   | month?  |          |              |  |  |  |
| 3. Have you ever spent the hight in the hospital?  |     |     | 31. Do you have any rashes, pressure sores, or other skin problems?   |          |              |  |  |  |
| 4. Have you ever had surgery?  |     |     | 32. Have you ever had a herpes or MRSA skin infection?  |          | <u> </u>     |  |  |  |
| HEART HEALTH QUESTIONS ABOUT YOU   | Yes | No  | 33. Are you currently taking any medication on daily basis?   | □+       |              |  |  |  |
| <ol><li>Have you ever passed out or nearly passed out DURING or<br/>AFTER exercise?</li></ol>  |     |     | 34. Have you ever had a head injury or concussion? If so, date of last injury:                                |          |              |  |  |  |
| 6. Have you ever had discomfort, pain, or pressure in your chest<br>during exercise?   |     |     | 35. Have you ever had numbness, tingling, or weakness in<br>your arms or legs after being hit or falling?     |          |              |  |  |  |
| 7. Does your heart race or skip beats during exercise?   |     |     | 36. Do you have headaches with exercise?  |          |              |  |  |  |
| 8. Has a doctor ever told you that you have (check all that apply):  | T   |     |   |          |              |  |  |  |
| ☐ High Blood Pressure ☐ A heart murmur☐ High cholesterol ☐ A heart infection☐ Kawasaki disease ☐ Other:  |     |     | 37. Have you ever been unable to move your arms or legs after being hit or falling?                           |          |              |  |  |  |
| 9. Has a doctor ever ordered a test for your heart?  |     |     | 38. When exercising in heat, do you have severe muscle  |          |              |  |  |  |
| (For ex: ECG/EKG, echocardiogram)  | Ш   |     | cramps or become ill?   |          |              |  |  |  |
| 10. Do you get lightheaded or feel more short of breath than expected during exercise?   |     |     | 39. Has a doctor told you that you or someone in your family<br>has sickle cell trait or sickle cell disease? |          |              |  |  |  |
| 11. Have you ever had an unexplained scizure?  |     |     | 40. Have you had any other blood disorders?   |          |              |  |  |  |
| HEART HEALTH QUESTIONS ABOUT YOUR FAMILY   | Yes | No  | 41. Have you had any problems with your eyes or vision?   |          |              |  |  |  |
| <ol> <li>Has any family member or relative died of heart problems or<br/>had an unexpected sudden death before age 50 (including drowning,</li> </ol>        |     |     | 42. Do you wear glasses or contact lenses?  |          |              |  |  |  |
| unexplained car accident, or sudden infant death syndrome)?  13. Does anyone in your family have a heart problem?  |     |     | 43. Do you wear protective eyewear, such as goggles or a  |          |              |  |  |  |
| Does anyone in your family have a pacemaker or implanted   | Ш_  | II  | face shield?  |          |              |  |  |  |
| defibrillator?   |     |     | 44. Do you worry about your weight?   |          |              |  |  |  |
| <ol> <li>Does anyone in your family have Marfan syndrome,<br/>cardiomyopathy, or Long Q-T?</li> </ol>  |     |     | 45. Are you trying to or has any professional recommended that you try to gain or lose weight?                |          |              |  |  |  |
| 16. Has anyone in your family had unexplained fainting,<br>unexplained seizures, or near drowning?   |     |     | 46. Do you limit or carefully control what you eat?   |          |              |  |  |  |
| BONE AND JOINT QUESTIONS   | Yes | No  | 47. Do you have any concerns that you would like to discuss with a doctor?                                    |          |              |  |  |  |
| 17. Have you ever had an injury, like a sprain, muscle or ligament<br>tear, or tendonitis that caused you to miss a practice or game?                        |     |     | 48. What is the date of your last Tdap or Td(tetanus) immunization? (circle type) Date:                       |          |              |  |  |  |
| 18. Have you had any broken or fractured bones or dislocated joints?   |     |     | 49.Do you have an allergy to medicine, food or stinging insects?  |          | П            |  |  |  |
|  |     |     |   | 니        |              |  |  |  |
| <ol> <li>Have you had a bone or joint injury that required x-rays, MRI,<br/>CT, surgery, injections, rehabilitation, physical therapy, a</li> </ol>          |     |     | FEMALES ONLY 50. Have you ever had a menstrual period?  |          |              |  |  |  |
| brace, a cast, or crutches?  | ш   |     | 30. Have you ever had a menstrual period?   |          | ш            |  |  |  |
| 20. Have you ever had an x-ray of your neck for atlanto-axial instability? OR Have you ever been told that you have that disorder or any neck/spine problem? |     |     | 51. Age when you had your first menstrual period?   |          |              |  |  |  |
| 21. Have you ever had a stress fracture of a bone?   |     |     | 52. How many periods have you had in the last 12 months?  |          |              |  |  |  |
| 22. Do you regularly use a brace or assistive device?  | П   |     |   | -        |              |  |  |  |
| 23. Do you currently have a bone, muscle, or joint injury that   |     |     | EXPLAIN "YES" ANSWERS BELOW:  |          |              |  |  |  |
| bothers you?   |     |     | #»  |          | 1            |  |  |  |
| 24. Do any of your joints become painful, swollen, feel warm, or look red?   |     |     | #»  |          |              |  |  |  |
| 25. Do you have a history of juvenile arthritis or connective tissue disease?  |     |     | #»  |          | 1            |  |  |  |
| MEDICAL QUESTIONS  | Yes | No  |   |          |              |  |  |  |
| 26. Do you cough, wheeze, or have difficulty breathing during or after exercise?   |     | - 🗆 | #»  |          |              |  |  |  |
| 27. Do you have asthma or use asthma medicine (inhaler,  |     |     | #»  *List medications and nutritional supplements you are currently take                                      |          |              |  |  |  |
| 28. Were you born without or are you missing a kidney, an eye, a testicle, spleen or any other organ?  |     |     | List medications and nutritional supplements you are currently fak  | ug here: |              |  |  |  |
| control of any other organi  |     | ٦   |   |          |              |  |  |  |

| <b>☆</b> ▶ | Parent/Guardian Signature: | Date: | Athlete's Signature: |  |
|------------|----------------------------|-------|----------------------|--|



## PART III - PHYSICAL EXAMINATION

Page 3 of 4

(Physical examination form is required each school year dated after May 1 of the preceding school year and is good through June 30th of the current school year)\*\*

| NAME                           |                         | Date of Birth  |             | School _   |  |
|--------------------------------|-------------------------|--|-------------|--|--|
|                                |                         | a the same and the   |             |  |  |
| Height                         | Weight                  |  | ☐ Malc      | ☐ Female   |  |
| BP /                           | Resting Pulse           | Vision R 2   |             | L 20/  | Corrected ☐ Yes ☐ No                           |
|                                | 8-                      |  |             |  |  |
| MEDICAL                        | NORMAL                  |  | ABNO        | ORMAL FIN  | DINGS  |
| Appearance                     |                         | 3  | 12271       |  |  |
| Eyes/ears/nose/throat          |                         |  | ***         | L-ML - LANCE   |  |
| Lymph nodes                    |                         |  |             |  |  |
| Heart                          |                         |  |             |  |  |
| Pulses                         |                         |  |             | And the second s |  |
| Lungs                          |                         |  |             |  |  |
| Abdomen                        |                         |  |             |  |  |
| Genitourinary (males only)     |                         | · · · · · · · · · · · · · · · · · · ·  |             |  |  |
| Skin                           |                         | 100 to 10 |             |  |  |
| Skill                          |                         |  |             |  |  |
| Navadasia                      |                         |  |             |  |  |
| Neurologic  MUSCULOSKELETAL    | NODMAY                  |  | A DNI       | DDMAY EIN  | DINCE  |
| Neck                           | NORMAL                  |  | ABING       | ORMAL FIN  | DINGS  |
| Back                           |                         | Manual Ma |             |  |  |
| ENTRONE.                       |                         |  |             |  |  |
| Shoulder/arm                   |                         |  |             |  |  |
| Elbow/forearm                  | -                       | - The Section 1  |             |  |  |
| Wrist/hand/fingers             |                         |  |             |  |  |
| Hip/thigh                      | -                       |  |             |  |  |
| Knee                           |                         |  |             |  |  |
| Leg/ankle                      |                         |  |             |  |  |
| Foot/toes                      |                         |  |             |  |  |
| Functional                     |                         |  |             |  |  |
| Medical Practitioner to        |                         | se indicate any instruc  | ctions or   | r recommen   | dations here)                                  |
| Emergency medications require  | d on-site               | Применя Повет  | Поль        |  |  |
| Comments:                      | Innaier                 | ☐ Epinephrine ☐ Glucagor   | n 🔲 Otne    | r:   |  |
| Comments:                      |                         |  |             |  |  |
|                                |                         |  |             |  |  |
|                                |                         |  |             |  |  |
| I have reviewed the data shave | ravioured big/her modi  | ant history form and make th   | no followi  | n a racommanda   | ations for his/her participation in athletics. |
|                                |                         |  | ie ionown   | ng recommenda  | mons for mis/her participation in atmetics.    |
|                                | OUT RESTRICTION         |  |             |  |  |
|                                | FOLLOWING NO            |  |             |  |  |
| ☐ Cleared AFTER do             | ocumented further ev    | aluation or treatment for:   |             |  |  |
|                                |                         |  |             |  |  |
| Cleared for Limited            | 1 participation (che    | ck and explain "reason" f  | or all that | t apply): "Limi  | ited Until Date" when appropriate              |
|                                |                         |  |             |  |  |
| ☐ Not cleared                  | d for (specific sports) | )  |             |  | Until Date:                                    |
| Peacon(s):                     |                         |  |             |  |  |
| Reason(s).                     | ·                       |  |             |  |  |
| □ NOT CLEARED F                | FOR PARTICIPAT          | ION Reason   |             |  |  |
|                                |                         |  |             |  | ing a review of Part II – Medical History.     |
| ,                              |                         | •  |             |  |  |
| Physician Signature:           |                         |  | _(*MD, D0   | O, LNP, PA) . Da   | te**   |
|                                | 2.7.2                   |  | 5002        |  |  |
| Examiner's Name and degree     | (print):                | 5H   | Pł          | none Number  |  |
| Address:                       |                         | City   | State       | Zip  |  |
| + Only signatures of L         | Doctor of Medicine, D   | octor of Osteopathic Medic   | cine, Nurs  | e Practitioner   | or Physician's Assistant licensed to           |