SPORTS Pre-participation Physical Evaluation
(to be completed by student athlete)

Name ___________________________________________ Gender ________ Birthdate ________________

Cell Phone: ___________________ Home Phone: ___________________ Email: _____________________________

Please Circle  FR  SO  JR  SR  Sports: __________________________ __________________________

MEDICAL ISSUES

1. Have you had a medical illness (particularly a severe viral or flu-like illness) or injury since your last checkup or sports physical? YES  NO

2. Have you had infectious mononucleosis (“mono”)? YES  NO

3. Do you have any ongoing/chronic medical illnesses (diabetes, heart condition, etc.)? YES  NO

4. Do you have asthma? YES  NO

5. Do you have trouble breathing, cough, or wheeze during or after exercise? YES  NO

6. Have you been hospitalized overnight? If so, please describe on back of page. YES  NO

7. Have you seen a doctor because of an injury? YES  NO

8. Have you had surgery? If so, please describe on back of page. YES  NO

MEDICATIONS/SUPPLEMENTS (Last 12 Months Only)

9. Are you regularly taking any medications (prescription or non-prescription) or using an inhaler? PLEASE INCLUDE BIRTH CONTROL, ADDERALL/RIATALIN If so, please describe on back of page. YES  NO

10. Have you been diagnosed with attention deficit disorder (ADD)? NOTE: THE NCAA REQUIRES DOCUMENTATION OF FORMAL ADD TESTING YES  NO

11. Are you presently taking vitamins, supplements to gain or lose weight, or supplements to aid performance? ALL SUPPLEMENT USE MUST BE REPORTED! YES  NO

ALLERGIES (Last 12 Months Only)

12. Do you have any allergies to medications, pollens, foods, or stinging insects? YES  NO

13. Have you developed a rash or hives during or after exercise? YES  NO

HEART ISSUES (Last 12 Months Only)

14. Have you had chest pain during or after exercise? If so, please describe on back of page. YES  NO

15. Have you been told that you have a heart murmur? YES  NO

16. Have you “passed out” during or after exercise? YES  NO

17. Have you felt dizzy during or after practice or competition? YES  NO

18. Do you tire more quickly with exertion than your teammates? YES  NO

19. Have you been diagnosed with high blood pressure or high cholesterol? YES  NO

20. Have you had an electrocardiogram (EKG), echocardiogram (sound wave test of the heart), or been evaluated by a heart specialist? YES  NO

21. Have you had severe or repeated racing of your heart or skipped heartbeats? YES  NO

22. Has anyone in your family died of heart problems or of sudden death before age 50? YES  NO

23. Has a physician denied or restricted your athletic participation for any reason? YES  NO
NEUROLOGIC ISSUES (Last 12 Months Only)
24. Have you had a head injury or concussion? **If so, please describe on back of page.**
   YES NO
25. Have you been “knocked out,” lost consciousness, or lost memory?
   YES NO
26. Have you had a seizure?
   YES NO
27. Do you suffer from frequent or severe headaches, particularly with exercise?
   YES NO
28. Have you had a “stinger,” “burner,” or pinched nerve?
   YES NO
29. Have you experienced numbness or tingling in your arms, hands, legs, or feet after being hit or falling?
   YES NO

ORTHOPAEDIC ISSUES (Last 12 Months Only)
30. Have you had broken bones, dislocations, sprains or tendonitis that caused you to miss a practice or game?
   YES NO
31. Have you had a stress fracture?
   YES NO
32. Do you use any special equipment (braces, neck rolls, eye guards, orthotics, etc.)?
   YES NO

NUTRITION (Last 12 Months Only)
33. Do you have concerns about your EATING HABITS or have you been diagnosed with an EATING DISORDER or IRON DEFICIENCY/ANEMIA?
   YES NO
34. Do you want to weigh more or less than you do?
   YES NO
35. Do you lose weight regularly to meet the weight requirements/demands of your sport?
   YES NO
36. Do you often skip meals or strictly limit/control what you eat?
   YES NO

MISCELLANEOUS CONCERNS (Last 12 Months Only)
37. Have you or a family member been diagnosed with SICKLE CELL DISEASE/TRAIT?
   YES NO
38. When exercising in the heat, do you have severe muscle cramps or become ill?
   YES NO
39. Have you been diagnosed with depression, anxiety, or panic attacks?
   YES NO
40. Have you had any skin problems (acne, warts, herpes, etc.)?
   YES NO
41. Have you had any trouble with your eyes or vision?
   YES NO
42. Do you wear contact lenses/glasses?
   YES NO

FOR WOMEN ONLY:
1. At what age was your first menstrual period?
2. When was your last menstrual period?
3. What was the longest time between periods last year?
4. How many menstrual periods did you have in the last 12 months?
5. Have you previously or are now on birth control pills?

Explain “Yes” answers below.

Please list any additional comments that you wish to make about your medical history.

To the best of my knowledge, I hereby state that my answers to the above questions are accurate.

Signature of athlete Date Signature of parent/guardian if student is under 18 Date
Physical Examination *(to be completed by medical provider)*

Student’s Name ___________________________ Date of Physical: ___________________________

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Clearance:  
A. Cleared  
B. Cleared after completing evaluation/rehabilitation for: __________________________
C. Not cleared for:  
  - Collision  
  - Contact  
  - Non-contact  
  - Strenuous  
  - Moderately strenuous  
  - Non-strenuous  

Due to: __________________________

Recommendation: __________________________

Medical provider signature/stamp or a copy of the medical provider’s document must be attached.  

_________________________  
MD, NP, or PA’s Signature  

_________________________  
MD, NP, or PA’s Printed Name  

Address, City, State