FORM C

Arkansas Activities Association Physical Exam Form

Master Problem List	Date Identified	Date Resolved
1.________________		
2.________________		
3.________________		
4.________________		

Date Entrance Physical Examination________________

PAST MEDICAL HISTORY: Since your initial preparticipation physical examination have you had any of the following? (If yes, please explain what, where and when)

	Yes	No	Explanation
1. Presently taking medication (including birth control pills)?	________	________	
2. Allergic to medicine, food, bee-sting?	________	________	
3. Wearing any new appliances - glasses, contact lenses, dentures or hearing aids?	________	________	
4. History of braces, chipped teeth, bridges?	________	________	
5. New medical problem requiring treatment or medication?	________	________	
6. Surgical operations or accidents requiring medical help?	________	________	
7. Injuries directly related to sports participation? (If so, explain nature of injury)	________	________	
8. Recent fainting or dizziness while exercising?	________	________	
9. Recent head injury of loss of consciousness?	________	________	
10.(For women) Date of last menstrual period?	________________		

REVIEW OF SYSTEMS: Please check if you have developed any new problem to the following areas of your body since your last physical exam.

________Skin ________Neck ________Head ________Lungs ________Knees ________Eyes ________Heart

________Mouth/Throat ________Abdomen ________Hips, Legs, Feet ________Blood ________Urination, bowel

________Shoulders, arms, hands ________Genital (including menstrual for females)

________Nutrition, weight control ________Muscle strength, feeling ________Mental, emotional

I would like to meet with the team physician ________Yes ________No

I certify that the above information is correct to the best of my knowledge.

Student/Parent Signature________________

VITAL SIGNS:

Height_________ Weight_________

Vision Screening (optional) (R) 20/________ (L) 20/________w/o Glasses

(R) 20/________ (L) 20/________with Glasses

Blood Pressure________________ Pulse________________

Other Testing:

REVIEW BY MEDICAL STAFF:

Approved for participation________________ Other disposition________________

Must see physician________________

Medical Personnel Signature________________Date________________

FORM A

Preparticipation Physical Evaluation

HISTORY Date________

Name__________________________ Sex__________ Age__________ Date of birth__________

Grade__________ Sport______________________________

Personal physician__________________________ ______________________ ______________________

Physician's Address Physician's Phone

Explain "Yes" answers below:

1. Have you ever been hospitalized? .... _____Yes _____No
2. Are you presently taking any medications or pills? .... _____Yes _____No
3. Do you have any allergies (medicine, bees or other stinging insects)? .... _____Yes _____No
4. Have you ever passed out during or after exercise? .... _____Yes _____No
5. Have you ever been dizzy during or after exercise? .... _____Yes _____No
6. Have you ever had chest pain during or after exercise? .... _____Yes _____No
7. Do you tire more quickly than your friends during exercise? .... _____Yes _____No
8. Have you ever had high blood pressure? .... _____Yes _____No
9. Have you ever been told that you have a heart murmur? .... _____Yes _____No
10. Have you ever had racing of your heart of skipped heartbeats? .... _____Yes _____No
11. Has anyone in your family died of heart problems or a sudden death before age 50? .... _____Yes _____No
12. Do you have any skin problems (itching, rashes, acne)? .... _____Yes _____No
13. Have you ever had a head injury? .... _____Yes _____No
14. Have you ever been knocked out or unconscious? .... _____Yes _____No
15. Have you ever had a seizure? .... _____Yes _____No
16. Have you ever had a stinger, burner or pinched nerve? .... _____Yes _____No
17. Have you ever had heat or muscle cramps? .... _____Yes _____No
18. Have you ever been dizzy or passed out in the heat? .... _____Yes _____No
19. Do you have trouble breathing or do you cough during or after activity? .... _____Yes _____No
20. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc)? .... _____Yes _____No
21. Have you had any problems with your eyes or vision? .... _____Yes _____No
22. Do you wear glasses or contacts or protective eye wear? .... _____Yes _____No
23. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints? .... _____Yes _____No

_____Head _____Shoulder _____Thigh _____Neck _____Elbow _____Knee _____Chest _____Forearm
_____Shin/Calf _____Back _____Wrist _____Ankle _____Hip _____Hand _____Foot

24. Have you had any other medical problems (infectious mononucleosis, diabetes, etc.)? .... _____Yes _____No
25. Have you had a medical problem or injury since your last evaluation? .... _____Yes _____No
26. When was your last tetanus shot? .... __________
27. When was your last measles immunization? .... __________
28. When was your first menstrual period? .... __________
29. When was your last menstrual period? .... __________
30. When was the longest time between your periods last year? .... __________

Explain "Yes" answers:

____
____
____
____

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

Signature of parent/guardian ______________________ Date ______________________

Signature of athlete ______________________ Date ______________________

FORM B

Preparticipation Physical Evaluation *(continued)*

Physical Examination Date _______________

Name ____ Age __________ Date of birth _______________

Height__________ Weight__________ BP__________ / __________ Pulse__________
Vision (R) 20/ __________ (L) 20/__________ Corrected Y N Pupils ________

			Normal	Abnormal Findings				Initial
COMPLETE	LIMITED	Cardiopulmonary						
		Pulses						
		Heart						
		Lungs						
		Tanner Stage	1	2	3	4	5	
		Skin						
		Abdominal						
		Genitalia						
		Musculoskeletal						
		Neck						
		Shoulder						
		Elbow						
		Wrist						
		Hand						
		Back						
		Knee						
		Ankle						
		Foot						
		Other						

Clearance: A. Cleared
B. Cleared After completing evaluation/rehabilitation for ______________________________
C. Not cleared for: _____Collision _____Contact
_____Noncontact _____Strenuous _____Moderately strenuous _____Nonstrenuous

Due to:____

Recommendation: ____

____

Name of Physician/Medical Personnel ______________________________ Date ______________

Address ____ Phone ______________

Signature of Physician/Medical Personnel ______________________________