Preparticipation Physical Parent/ Guardian Questionnaire

Name: _____ **Sex: M / F** **DOB:** _____

Please answer the following questions to the best of your knowledge and explain any "yes" answers in the space provided below.

Y N

1. ☐ ☐ Have you had a medical illness or injury since your last check up or sports physical?
2. ☐ ☐ Do you have a chronic or ongoing illness?
3. ☐ ☐ Have you been hospitalized overnight?
4. ☐ ☐ Have you ever had surgery?
5. ☐ ☐ Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?
6. ☐ ☐ Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?
7. ☐ ☐ Do you have any allergies (for example to pollen, medicine, food, or stinging insects)?
8. ☐ ☐ Have you ever had a rash or hives develop during or after exercise?
9. ☐ ☐ Have you ever passed out from exercise?
10. ☐ ☐ Have you been dizzy from exercise?
11. ☐ ☐ Have you ever had chest pain during or after exercise?
12. ☐ ☐ Do you get tired more quickly than your friends do during exercise?
13. ☐ ☐ Have you ever had racing of your heart or skipped heartbeats?
14. ☐ ☐ Do you have high blood pressure/cholesterol?
15. ☐ ☐ Have you been told you have a murmur?
16. ☐ ☐ Has any family member or relative died of heart problems or of sudden death before age 50?
17. ☐ ☐ Have you had a severe viral infection within the last month?
18. ☐ ☐ Has a physician ever denied or restricted your participation in sports for any heart problems?
19. ☐ ☐ Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?
20. ☐ ☐ Have you ever had a concussion/ head inujury?
21. ☐ ☐ Have you ever been knocked out, become unconscious, or lost your memory?
22. ☐ ☐ Have you ever had a seizure?

Y N

23. ☐ ☐ Do you have frequent/ severe headaches?
24. ☐ ☐ Have you ever had numbness or tingling in your arms, hands, legs, or feet?
25. ☐ ☐ Have you ever had a pinched nerve?
26. ☐ ☐ Have you been ill from exercising in the heat?
27. ☐ ☐ Do you cough, wheeze, or have trouble breathing during or after activity?
28. ☐ ☐ Do you have asthma?
29. ☐ ☐ Do you have seasonal allergies that require medical treatment?
30. ☐ ☐ 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)?
31. ☐ ☐ Have you had problems with your eyes/ vision?
32. ☐ ☐ Do you wear glasses, contacts, or protective eyewear?
33. ☐ ☐ Have you ever had a sprain, strain, or swelling after injury?
34. ☐ ☐ Have you broken bones or dislocated joints?
35. ☐ ☐ Have you had any other problems with pain or swelling in muscles, tendons, bones,or joints? If yes, check appropriate answer and explain below.

☐ Head	☐ Elbow	☐ Hip
☐ Neck	☐ Forearm	☐ Thigh
☐ Back	☐ Wrist	☐ Knee
☐ Chest	☐ Hand	☐ Shin
☐ Shoulder	☐ Finger	☐ Ankle
☐ Upper arm		☐ Foot

36. ☐ ☐ Are you happy with your weight?
37. ☐ ☐ Do you lose weight regularly to meet weight requirements for your sport?
38. ☐ ☐ Do you feel stressed out?

Females Only

Onset of menstruation: _____
Date of most recent period: _____
Length of cycle (days): _____
periods in last 12 months: _____

Explain "Yes" answers: _____

_____

_____

_____

The answers to the above questions are complete and accurate to the best of my knowledge. I grant permission for my student to have a physical examination by the school physician or his/her designee.

Parent/Guardian Signature: _____ **Date**_____

8/18/08

PREPARTICIPATION PHYSICAL EVALUATION

Name: _____ **Date of Birth:** _____

Height: _____ **Weight:** _____ **BMI:** _____ **Pulse:** _____ **BP:** ____ / ____

Vision: ***Near*** **R 20/** _____ **L 20/** _____ ***Distance*** **R 20/** _____ **L 20/** _____

Corrected: Y / N Pupils: Equal / Unequal

	Normal	Abnormal Findings
Eyes/ Ears/ Nose/ Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		
Neck		
Back		
Shoulder/ arm		
Elbow/ forearm		
Wrist/ hand		
Hip/ thigh		
Knee		
Leg/ ankle		
Foot		

Full Clearance for sports participation? Yes / No
Limited Clearance (please specify):
No Clearance (include recommendations):

Health Care Provider Name (print/ type): _____

HCP Phone #: _____ Date of Examination: _____

Health Care Provider signature: _____

11/5/08