



■ PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM Name: Date of birth: Medically eligible for all sports without restriction Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of ☐ Medically eligible for certain sports □ Not medically eligible pending further evaluation ☐ Not medically eligible for any sports Recommendations: I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians). Name of health care professional (print or type): Address: ____ Phone: Signature of health care professional: , MD, DO, NP, or PA SHARED EMERGENCY INFORMATION Allergies: ___ Medications: Other information: Emergency contacts:

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Note: Complete and sign this form (with your parent Name:			pointment. te of birth:				
Date of examination:	Sport(s):			VAVA 1887			
iex assigned at birth (F, M, or intersex):	How do	How do you identify your gender? (F, M, or other):					
List past and current medical conditions.		- 1818.60	11				
Have you ever had surgery? If yes, list all past surgi	cal procedures,	-					
Medicines and supplements: List all current prescri	ptions, over-the-co	unter medicines, a	nd supplements (herbal	and nutritional).			
Do you have any allergies? If yes, please list all yo	ur allergies (ie, me	dicines, pollens, fo	ood, stinging insects).				
Patient Health Questionnaire Version 4 (PHQ-4)			1 210 1	1			
Over the last 2 weeks, how often have you been b			Over half the days				
Feeling nervous, anxious, or on edge	0	1	2	3			
Not being able to stop or control worrying	0	1	2	3			
Little interest or pleasure in doing things	0	1	2	3			
Feeling down, depressed, or hopeless	0	1	2	3			

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

(Ехр	ERAL QUESTIONS lain "Yes" answers at the end of this form. e questions if you don't know the answer.)	Yes	No
1.	Do you have any concerns that you would like to discuss with your pravider?		
2.	Has a provider ever denied or restricted your participation in sports for any reason?		
3.	Do you have any ongoing medical issues or recent illness?		
HEA	RT HEALTH QUESTIONS ABOUT YOU	Yes	No
4.	Have you ever passed out or nearly passed out during or after exercise?		
5.	Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6.	Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7.	Has a doctor ever told you that you have any heart problems?		
8.	Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

	RT HEALTH QUESTIONS ABOUT YOU NTINUED)	Yes	No
9.	Do you get light-headed or feel shorter of breath than your friends during exercise?		
10.	Have you ever had a seizure?		
HEA	RT HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
11.	Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
12.	Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13.	Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		



Name: __



Date of birth:

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PHYSICAL EXAMINATION FORM

PHYSICIAN REI	MINDERS							
1. Consider a	dditional que	estions	s on more-sen	sitive issues.				
Do you	feel stressed	out o	r under a lot a	of pressure?				
				sed, or anxious?				
Do you	feel safe at y	our h	ome or reside	ence?				
During	the 20 -	J	ام حدد دحد الثانة	L				
			aia you use ci se any other c	hewing tobacco, snuff, or dip?				
				or used any other performance-	enhancina supolem	ent?		
				o help you gain or lose weight				
Do you	wear a seat	belt, u	use a helmet, i	and use condoms?				
2. Consider re	eviewing que	stions	on cardiovas	scular symptoms (Q4-Q13 of H	istory Form).			
EXAMINATION	4			Alteres established			Cales a s	
Height:			Weight:			- Caren		
BP: /	(/)	Pulse:	Vision: R 20/	L 20/	Correc	ted: □Y	
MEDICAL	CONTRACTOR				(6,550) = 10,532-0.0		NORMAL	ABNORMAL FINDINGS
Appearance								
				ned palate, pectus excavatum, a portic insufficiency)	rachnodactyly, hype	rlaxity,		
Eyes, ears, nos	e, and throat					- UII		
 Pupils equa 	1						0	The state of the s
 Hearing 								30 M
Lymph nodes								
Heart ^e								
	uscultation st	andin	g, auscultatio	on supine, and ± Valsalva mane	uver)			
Lungs		_						
Abdomen							15	
Skin				a f Iralli a m d				
		V), le	isions suggesti	tive of methicillin-resistant Staph	ylococcus aureus (M	RSA), or		
Neurological	ris							
MUSCULOSKE	IFTA1					_	NORMAL	ABNORMAL FINDINGS
Neck	LLIAL	_					NORMAL	ABINORMAL PHADINGS
Back								enty a
Shoulder and a	ırm							
Elbow and fore	arm				h			
Wrist, hand, ar	nd fingers				STATE OF THE PERSON			
Hip and thigh								
Knee								
Leg and ankle								
Foot and toes								
FunctionalDouble-leg	squat test, sir	ngle-le	eg squat test, i	and box drop or step drop test				
				diography, referral to a cardiolo	gist for abnormal co	rdiac histo	ory or examin	ation findings, or a combi-
nation of those.								_
Name of health	care professi	onal (print or type):	:				
Address:							none:	
Signature of hea	ith care profe	ession	al:					, MD, DO, NP, or PA

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108	IE AND JOINT QUESTIONS	Yes	No
14.	Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15.	Do you have a bone, muscle, ligament, or joint injury that bothers you?		
AED	ICAL QUESTIONS	Yes	No
16.	Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17.	Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
18.	Do you have grain or testicle pain or a painful bulge or hernia in the grain area?		
19.	Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?		
20.	Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21.	Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22.	Have you ever become ill while exercising in the heat?		
23.	Do you or does sameone in your family have sickle cell trait or disease?		
24.	Have you ever had or do you have any prob- lems with your eyes or vision?		

MED	ICAL QUESTIONS (CONTINUED)	Yes	No
25.	Do you worry about your weight?		Sell Co
26.	Are you trying to or has anyone recommended that you gain or lose weight?		
27.	Are you on a special diet or do you avoid certain types of foods or food groups?		
28.	Have you ever had an eating disorder?		
FEM	ALES ONLY	Yes	No
29.	Have you ever had a menstrual period?		
30.	How old were you when you had your first menstrual period?		
31.	When was your most recent menstrual period?		
32.	How many periods have you had in the past 12 months?		

100		
		 0.0

I hereby state that, to the bes	t of my knowledge, my	answers to the question	s on this form are complete
and correct.			

Signature of athlete:	
Signature of parent or guardian:	
Date:	

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