The Medical Eligibility Form is the only form that **should be submitted** to a school or sports organization.

■ PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM			
Name: Dotte	e of birth:	Date of exam: _	
□ Medically eligible for all sports without restriction			
□ Medically eligible for all sports without restriction with recommendations for	r 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 praparent clinical contraindications to practice and can participate in the			
examination findings are on record in my office and can be made availal arise after the athlete has been cleared for participation, the physician and the potential consequences are completely explained to the athlete	may rescind the me e (and parents or gu	the request of the pardical eligibility until the ardians).	rents. If conditions e problem is resolved
examination findings are on record in my office and can be made availarise after the athlete has been cleared for participation, the physician and the potential consequences are completely explained to the athlete Name of health care professional (print or type):	may rescind the mee e (and parents or gu	the request of the pardical eligibility until the ardians). Date:	rents. If conditions e problem is resolved
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Disclaimer: Athletes who have a current Preparticipation Physical Evaluation (per state and local guidance) on file should not need to complete another History Form.

■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

HISTORY FORM

	Date of birth:
Date of examination:	Sport(s):
Sex assigned at birth (F, M, or intersex):	How do you identify your gender? (F, M, non-binary or other):
List past and current medical conditions.	
Have you ever had surgery? If yes, list all past s	urgical procedures.
Medicines and supplements: List all current preso	criptions, over-the-counter medicines, and supplements (herbal and nutritional)
Do you have any allergies? If yes, please list a	ill your allergies (ie, medicines, pollens, food, stinging insects).

Over the last 2 weeks, how often have you been both	ered by any o	f the following pro	blems? (Circle respon	se.)
**	Not at all	Several days	Over half the days	Nearly every day
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	e [questions 1 c	and 2, or questions 3	3 and 4] for screening p	ourposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
I. Do you have any concerns that you would like to discuss with your provider?		
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?		
HEART 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?		
Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)	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?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
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)?		
Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

BONE AND JOINT QUESTIONS	Yes	No	MEDICAL QUESTIONS (CONTINUED)
14. Have you ever had a stress fracture or an injury			25. Do you worry about your weight?
to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?			26. Are you trying to or has anyone recommended that you gain or lose weight?
5. Do you have a bone, muscle, ligament, or joint injury that bothers you?			27. Are you on a special diet or do you avoid certain types of foods or food groups?
EDICAL QUESTIONS	Yes	No	28. Have you ever had an eating disorder?
Do you cough, wheeze, or have difficulty breathing during or after exercise?			FEMALES ONLY
Se u			29. Have you ever had a menstrual period?
7. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?			30. How old were you when you had your first menstrual period?
Do you have groin or testicle pain or a painful bulge or hernia in the groin area?			31. When was your most recent menstrual period?
Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?			32. How many periods have you had in the past 12 months? Explain "Yes" answers here.
Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?			
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?			
. Have you ever become ill while exercising in the heat?			
Do you or does someone 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?			

and correct.

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?	
Explain "Yes" answers here.	

Yes

Yes

No

No

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

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete

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PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name:	Date of birth:
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PHYSICIAN REMINDERS

- 1. Consider additional questions on more-sensitive issues.
 - · Do you feel stressed out or under a lot of pressure?
 - · Do you ever feel sad, hopeless, depressed, or anxious?
 - Do you feel safe at your home or residence?
 - · Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
 - . During the past 30 days, did you use chewing tobacco, snuff, or dip?
 - · Do you drink alcohol or use any other drugs?
 - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
 - · Have you ever taken any supplements to help you gain or lose weight or improve your performance?
 - · Do you wear a seat belt, use a helmet, and use condoms?
- 2. Consider reviewing questions on cardiovascular symptoms (Q4-Q13 of History Form).

BP: / (/) Pulse: Vision: R 20/ L 20/ Cc	egikki asalka yan atau	
	orrected: DY	n N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat Pupils equal Hearing		
Lymph nodes		
Hearts Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs Abdomen		
Skin Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant Staphylococcus aureus (MRSA), or tinea corporis Neurological		
MUSCULOS KELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Lee and ankle		
Leg and ankle		
Foot and toes	1	
Foot and toes Functional Double-leg squat test, single-leg squat test, and box drop or step drop test Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history	or examination f	indings, or a combination of
Foot and toes Functional Double-leg squat test, single-leg squat test, and box drop or step drop test Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history those.		
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■ PREPARTICIPATION PHYSICAL EVALUATION

ATHLETES WITH DISABILITIES FORM: SUPPLEMENT TO THE ATHLETE HISTORY

Name:Date of birth:		
I. Type of disability:		
2. Date of disability:		
3. Classification (if available):		
4. Cause of disability (birth, disease, injury, or other):		
5. List the sports you are playing.		
3. List the sports you are playing.	Yes	No
6. Do you regularly use a brace, an assistive device, or a prosthetic device for daily activities?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
II. Do you use any special devices for bowel or bladder function?		
Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed as having a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
If the second results are as naving a near-related (hypertherma) or cold-related (hypotherma) limess: 15. Do you have muscle spasticity?	$\vdash \vdash \vdash$	
16. Do you have frequent seizures that cannot be controlled by medication?	\vdash	
	ш	
Explain "Yes" answers here.		
Please indicate whether you have ever had any of the following conditions:		
	Yes	No
Atlantoaxial instability		
Radiographic (x-ray) evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		
Explain "Yes" answers here.		
I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.		
Signature of athlete:		
I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct. Signature of athlete: Signature of parent or guardian: Date:		

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