Pre-Participation Physical Evaluation

This page to be completed by student and parent/guardian

Name ____________________________ Sex ________ Age ________ Date of Birth ________
Grade ________ School ____________________________ Sport(s) ____________________________
Address ____________________________________________
Personal physician ____________________________________________
In case of emergency, contact ____________________________________________
Name ____________________________ Relationship ____________________________ Phone (H) ________ (W) ________

Explain "Yes” answers below. Circle questions if you don’t know the answers.

1. Have you had a medical illness or injury since your last check up or sports physical?
   Yes ☐ No ☐

2. Have you ever been hospitalized overnight?
   Yes ☐ No ☐

3. Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler?
   Yes ☐ No ☐

4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?
   Yes ☐ No ☐

5. Have you ever passed out during or after exercise?
   Yes ☐ No ☐

6. Do you have any current skin problems (for example, itching, rash, acne, warts, fungus, or blisters)?
   Yes ☐ No ☐

7. Have you ever had a head injury or concussion?
   Yes ☐ No ☐

8. Have you ever become ill from exercising in the heat?
   Yes ☐ No ☐

9. Do you cough, wheeze, or have trouble breathing during or after activity?
   Yes ☐ No ☐

10. 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)?
    Yes ☐ No ☐

11. Have you had any problems with your eyes or vision?
    Yes ☐ No ☐

12. Have you ever had a sprain, strain, or swelling after injury?
    Yes ☐ No ☐

13. Do you want to weigh more or less than you do now?
    Yes ☐ No ☐

14. Do you feel stressed out?
    Yes ☐ No ☐

15. Record the dates of your most recent immunizations (shots) for:
    Tetanus ☐ Measles ☐
    Hepatitis B ☐ Chickenpox ☐

FEMALES ONLY

16. When was your first menstrual period?
    ____________________________
    When was your most recent menstrual period?
    ____________________________
    How much time do you usually have from the start of one period to the start of another?
    ____________________________
    How many periods have you had in the last year?
    ____________________________
    What was the longest time between periods in the last year?
    ____________________________

Explain “Yes” answers here:

__________________________________________

__________________________________________

__________________________________________

__________________________________________

__________________________________________

We hereby state that, to the best of our knowledge, our answers to the above questions are complete and correct.

Signature of athlete ____________________________ Signature of parent/guardian ____________________________ Date ________

Pre-Participation Physical Evaluation
(This page to be completed by physician/nurse practitioner/physician assistant)

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<th>ABNORMAL FINDING</th>
<th>INITIALS *</th>
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<tr>
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<td>Eyes/Ears/Nose/Throat</td>
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<td>Lymph nodes</td>
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<td>Heart</td>
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<td>Abdomen</td>
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<td>Genitalia (males only)</td>
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<td>Skin</td>
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<td>Neck</td>
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<td>Shoulder/Arm</td>
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<td>Leg/Ankle</td>
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<td>Foot</td>
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*Station-based examination only

CLEARANCE

☐ Cleared

☐ Cleared after completing evaluation/rehabilitation for:

________________________________________________________________________

________________________________________________________________________

☐ Not cleared for [Sport(s)]: ___________________________ Reason: ___________________________

Recommendation: __________________________________________

________________________________________________________________________

Name of physician/nurse practitioner/physician assistant __________________________ Date: ____________

Address: __________________________ Phone: __________________________

Signature of physician/nurse practitioner/physician assistant __________________________

PHYSICIANS STAMP: __________________________

Endorsed by the MPSSAA