Preparticipation Physical Evaluation

PHYSICAL EXAMINATION FORM

EXAMINATION & CLEARANCE FROM MUST BE COMPLETED BY A MEDICAL DOCTOR OR A DOCTOR OF ORTHOPEDICS.

PHYSICALS BY A CHIROPRACTOR WILL NO LONGER BE ACCEPTED.

Name:____Sex:______Age:______Date of Birth__________

Height:________Weight:________Body fat (optional)______Pulse________BP____/____ (____/____,____/____)

Vision: R 20/____ L 20/____ Corrected: Y N Pupils: Equal _________ Unequal ________

	NORMAL	FINDINGS & RECOMMENDATIONS	INITIALS
MEDICAL			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph Nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)			
Skin			
Musculoskeletal			
Neck			
Back			
shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/Toes			
*Multiple-examiner set-up only			

*Having a third party present is recommended for the genitourinary examination

SCHOOL: ___________________________________

☐ Cleared without restriction

☐ Cleared, with recommendations for further evaluation or treatment for:_______________________________

☐ Not cleared for: ☐ All Sports ☐ Certain sports:____

Reason:____

Recommedations:____

***Name of physician (print/Stamp)*____*Date*________________**

***Address*____*Phone*________________**

Signature of physician*____*, MD or DO

Charger Athletics

Charter Oak High School

1430 East Covina Blvd. Covina, Ca 91723-0009 · (626)915-5841

Date of Exam ____________________

Preparticipation Physical Evaluation — HISTORY FORM

Name ______________________________ Sex ______ Age ______ Date of birth __________

Grade ________ School ______________________________ Sport(s) ______________________

Address ____ Phone ______________

Personal Physician ____

In case of emergency, contact:

Name ______________________ Relationship __________ Home Phone ______________ Work Phone ______________

Explain "Yes" answers below. Circle questions you don't know the answers to.

Yes No

1. Has a doctor ever denied or restricted your participation in sports for any reason? ☐ ☐
2. Do you have an ongoing medical condition (like diabetes or asthma)? ☐ ☐
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? ☐ ☐
4. Do you have allergies to medicines, pollens, foods, or stinging insects? ☐ ☐
5. Have you ever passed out or nearly passed out DURING exercise? ☐ ☐
6. Have you ever passed out or nearly passed out AFTER exercise? ☐ ☐
7. Have you ever had discomfort, pain, or pressure in your chest during exercise? ☐ ☐
8. Does your heart race or skip beats during exercise? ☐ ☐
9. Has a doctor ever told you that you have (check all that apply):
   ☐ High blood pressure ☐ A heart murmur
   ☐ High cholesterol ☐ A heart infection
10. Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram) ☐ ☐
11. Has anyone in your family died for no apparent reason? ☐ ☐
12. Does anyone in your family have a heart problem? ☐ ☐
13. Has any family member or relative died of heart problems or of sudden death before age 50? ☐ ☐
14. Does anyone in your family have Marfan syndrome? ☐ ☐
15. Have you ever spent the night in a hospital? ☐ ☐
16. Have you ever had surgery? ☐ ☐
17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below: ☐ ☐
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below: ☐ ☐
19. Have you had a bone or joint injury that required x-rays MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below: ☐ ☐

Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/ Fingers	Chest
Upper Back	Lower Back	Hip	Thigh	Knee	Calf/ Shin	Ankle	Foot/ Toes

20. Have you ever had a stress fracture? ☐ ☐
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? ☐ ☐
22. Do you regularly use a brace or assistive device? ☐ ☐
23. Has a doctor ever told you that you have asthma or allergies? ☐ ☐
24. Do you cough, wheeze, or have difficulty breathing during or after exercise? ☐ ☐
25. Is there anyone in your family who has asthma? ☐ ☐
26. Have you ever used an inhaler or taken asthma medicine? ☐ ☐
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? ☐ ☐
28. Have you had infectious mononucleosis (mono) within the last month? ☐ ☐
29. Do you have any rashes, pressure sores, or other skin problems? ☐ ☐
30. Have you had a herpes skin infection? ☐ ☐
31. Have you ever had a head injury or concussion? ☐ ☐
32. Have you been hit in the head and been confused or lost your memory? ☐ ☐
33. Have you ever had a seizure? ☐ ☐
34. Do you have headaches with exercise? ☐ ☐
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? ☐ ☐
36. Have you ever been unable to move your arms or legs after being hit or falling? ☐ ☐
37. When exercising in the heat, do you have severe muscle cramps or become ill? ☐ ☐
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? ☐ ☐
39. Have you had any problems with your eyes or vision? ☐ ☐
40. Do you wear glasses or contact lenses? ☐ ☐
41. Do you wear protective eyewear, such as goggles or a face shield? ☐ ☐
42. Are you happy with your weight? ☐ ☐
43. Are you trying to gain or lose weight? ☐ ☐
44. Has anyone recommended you change your weight or eating habits? ☐ ☐
45. Do you limit or carefully control what you eat? ☐ ☐
46. Do you have any concerns that you would like to discuss with a doctor? ☐ ☐

FEMALES ONLY

47. Have you ever had a menstrual period? ☐ ☐
48. How old were you when you had your first menstrual period? ______
49. How many periods have you had in the last 12 months? ______

Explain "Yes" answers here: ____

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

Signature of Athlete ______________________ Signature of Parent/Guardian ______________________ Date ______

Modified from American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine, 2004. Rev. 5/05

White copy – SMC *Yellow copy – SCHOOL* *rev 4/13/09*