



PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM _____ Date of birth: _____ Name: ☐ 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 \square 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). Address: Phone: Signature of health care professional: ____ , MD, DO, NP, or PA SHARED EMERGENCY INFORMATION Allergies: Other information: ___ Emergency contacts: ____

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HISTORY FORM

Note: Complete and sign this form (with your parent Name:	
	Sport(s):
Sex assigned at birth (F, M, or intersex):	How do you identify your gender? (F, M, or other):
List past and current medical conditions.	
Have you ever had surgery? If yes, list all past surgi	ical procedures.
Medicines and supplements: List all current prescri	ptions, over-the-counter medicines, and supplements (herbal and nutritional).
Do you have any allergies? If yes, please list all yo	our allergies (ie, medicines, pollens, food, stinging insects).

Patient Health Questionnaire Version 4 (PHQ-4) Over the last 2 weeks, how often have you been be	pothered by any of	the following prob	lems? (Circle response.)
	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 \geq 3 is considered positive on either	r subscale [question	ns 1 and 2, or que	stions 3 and 4] for scre	ening purposes.)

GEN (Exp Circl	Yes	No	
1.	Do you have any concerns that you would like to discuss with your provider?		
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.		

HEA (CO	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?		

14.	Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that			25. Do you worry about your weight?		
	caused you to miss a practice or game?			26. Are you trying to or has anyone recommended that you gain or lose weight?		
15.	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?		
MEI	DICAL QUESTIONS	Yes	No	28. Have you ever had an eating disorder?		
16.	Do you cough, wheeze, or have difficulty breathing during or after exercise?			FEMALES ONLY	Yes	No
17.	Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?			29. Have you ever had a menstrual period? 30. How old were you when you had your first menstrual period?		<u> </u>
18.	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?		
19.	Do you have any recurring skin rashes or			32. How many periods have you had in the past 12 months?		
	rashes that come and go, including herpes or methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)?			Explain "Yes" answers here.		
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 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?					

Yes No

BONE AND JOINT QUESTIONS

Date: _

MEDICAL QUESTIONS (CONTINUED)

Yes No

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Name: __

Leg and ankle Foot and toes Functional

• Double-leg squat test, single-leg squat test, and box drop or step drop test

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Date of birth:

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PHYSICAL EXAMINATION FORM

I II I SICIAN KE	MINDERS							
			s on more-sensiti					
			r under a lot of p					
			eless, depressed nome or residence					
• Do you	reer sare a	r your r	ome or residence	e•				
-	the past 30) davs	did vou use chev	ving tobacco, snuff, or dip?				
			se any other dru					
				used any other performance-er	hancing suppleme	ent?		
				elp you gain or lose weight or				
Do you	wear a sec	at belt,	use a helmet, and	d use condoms?				
2. Consider r	eviewing qu	estions	on cardiovascul	ar symptoms (Q4–Q13 of Hist	ory Form).			
EXAMINATIO	V							
Height:	•		Weight:					
BP: /	1 /	1	Pulse:	Vision: R 20/	L 20/	Correc	ted: □Y	
MEDICAL	(/		1 0130.	V131011. IX 207	2.207	Correc	NORMAL	ABNORMAL FINDINGS
Appearance							HORMAL	ADITORINALTINDINGS
1.1	ımata (kvoh	مدحمانم	sis high-arched	palate, pectus excavatum, ara	chnodactyly hyner	lavity		
			: [MVP], and aor		ciliodaciyiy, fiyper	idxiiy,		
Eyes, ears, nos			[////], and dor	ne moomereney j				
 Pupils equal 		ui						
Hearing	"							
Lymph nodes								
Hearta /a		ما: ا	م معالمان می	uning and + Valentus manaun	اسم			
	luscultation	stanair	ig, auscultation s	upine, and ± Valsalva maneuv	erj			
Lungs								<u> </u>
Abdomen								
Skin					***			
		HSV), le	sions suggestive	of methicillin-resistant Staphylo	ococcus aureus (M	RSA), or		
tinea corpo	ris							
Neurological								
MUSCULOSKE	LETAL						NORMAL	ABNORMAL FINDINGS
Neck								
Back								
Shoulder and a	arm							
Elbow and fore	earm							
Wrist, hand, a	nd fingers							
Hip and thigh	<u> </u>							
Knee								

^a Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.