

Westerly High School



PRE-PARTICIPATION PHYSICAL EVALUATION

To be completed by athlete and parent:

Date: _____

Student-Athlete's Name: _____
Last First Middle

Address: _____
Street

_____ Phone: (_____) _____
City/State Zip

School: Westerly High School Grade: _____

Date Of Birth: _____ Age _____ Sex _____

Emergency Contact Person: _____

Emergency Phone: (_____) _____

Family Doctor: _____

Address: _____
Street

_____ *City/State Zip*

Phone: (_____) _____

Pre-Participation History and Physical Exam

HISTORY

General

- | | Yes | No |
|--|------------|-----------|
| 1. Have you had a medical illness or injury since your last check up or sports physical? | ___ | ___ |
| 2. Do you have an ongoing or chronic illness? _____ | ___ | ___ |
| 3. Have you ever been hospitalized overnight? | ___ | ___ |
| 4. Have you ever had surgery? | ___ | ___ |
| 5. Are you currently taking any prescription or non-prescription (over the counter) medications or pills? | ___ | ___ |
| a. prescription _____ | ___ | ___ |
| b. non-prescription _____
<i>(over the counter)</i> | ___ | ___ |
| 6. Do you have any allergies (for example: to pollen, medicine, or stinging insects)?
If yes, which one(s)? _____ | ___ | ___ |
| 7. Do you have any dental prosthetic devices (i.e., bridges, crowns) | ___ | ___ |
| 8. Have you had any problems with your eyes or vision? What: _____ | ___ | ___ |
| 9. Do you wear glasses, contacts, or protective eyewear? Which: _____ | ___ | ___ |
| 10. Do you have any current skin problems? What: _____ | ___ | ___ |
| 11. Have you ever fainted or become ill from exercising in the heat? When? _____ | ___ | ___ |
| 12. Do you smoke?, how many packs per day? _____ | ___ | ___ |
| 13. Do you have only one of a normally paired organ (i.e. kidney, lung, eye, testicle)?
If yes, which one(s)? _____ | ___ | ___ |

Heart

- | | Yes | No |
|---|------------|-----------|
| 1. Have you ever passed out during or after exercise? | ___ | ___ |
| 2. Have you ever been dizzy after exercise? | ___ | ___ |
| 3. Have you ever had chest pain during or after exercise? | ___ | ___ |
| 4. Have you ever had racing of your heart or skipped heartbeats? | ___ | ___ |
| 5. Have you ever been told you have a heart murmur? | ___ | ___ |
| 6. Has any family member or relative died of heart problems or of sudden death before age 50? | ___ | ___ |
| 7. Have you had a viral infection (for example: mononucleosis) within the last year?
If yes, what? _____ | ___ | ___ |
| 8. Has a physical ever denied or restricted your participation in sports for any heart problems? | ___ | ___ |

Lung

- | | Yes | No |
|--|------------|-----------|
| 1. Do you cough, wheeze, or have trouble breathing during or after activity? | ___ | ___ |
| 2. Do you have asthma? | ___ | ___ |
| 3. Do you use an inhaler? | ___ | ___ |

Musculo-Skeletal

- | | Yes | No |
|---|------------|-----------|
| 1. 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)? What: _____ | ___ | ___ |
| 2. Have you ever had a sprain, strain, or swelling after injury which prevented you from participation? What / When: _____ | ___ | ___ |
| 3. Have you broken or fractured any bones or dislocated any joints?
What / When: _____ | ___ | ___ |

Head

Yes No

- 1. Have you had a head injury or a concussion? When: _____
- 2. Have you ever been knocked out, become unconscious, or lost your memory?
When / What: _____
- 3. Have you ever had a seizure? When: _____
- 4. Have you ever had a stinger, burner, or numbness in your arms, hands, legs or feet?
If yes, which one(s)? _____

___ ___
 ___ ___
 ___ ___
 ___ ___

Nutrition

Yes No

- 1. Do you skip meals during the day?
- 2. Do you use laxatives, diuretics, or stimulants to control your weight?
If yes, what? _____
- 3. Do you feel disgusted, depressed, or guilty about your eating?
- 4. Do you self-induce vomiting after eating?
- 5. Do you restrict certain types of foods?
If yes, what _____
- 6. Have you ever taken nutritional supplements?
If yes, what: _____
- 7. Do you have a food allergy?
If yes, what: _____
- 8. Do you want to weigh more or less than you do now? _____

___ ___
 ___ ___
 ___ ___
 ___ ___
 ___ ___
 ___ ___
 ___ ___

FEMALES ONLY

- 1. When was your last menstrual period? _____
- 2. How often do your periods occur? _____
- 3. Have you ever gone 4 months without getting a period? _____

Parental Permission and Authorization for Treatment

We hereby give our consent for _____ to represent his/her school in interscholastic athletics. If in the event of injury or accident either en route to the event, at the event, or en route back from the event, we also give our consent for the school to obtain any and all medical care that is deemed reasonably necessary for the welfare of the student. We realize that all reasonable efforts will be made to contact us if the above does occur.

We further state that we have completed that part of this form which requires us to list all previous injuries or conditions that are known to us and that the form is completed correct and true.

Name of Primary Medical Insurance: _____

Policy Number: _____ Expiration Date: _____

Parent or Guardian (PRINT): _____

Signature of Parent or Guardian: _____

Name: _____

Sport(s): _____

Date of Physical: _____

PHYSICAL EXAMINATION

Age: _____

Height: _____ Weight: _____

Pulse: _____ BP: _____, _____, _____

Vision: R _____ L _____ Corrected: Y N

	Normal	Explanation
Medical		
General		
Skin		
HEENT		
Lymph Nodes		
Heart		
Lungs		
Abdomen		
Genitalia (males only)		
Pulses		
Musculo-Skeletal		
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Calf		
Ankle/Foot		
Neurologic		

IMMUNIZATIONS:

- 1. When was your last tetanus shot? _____
- 2. When was your last (MMR) measles shot? _____
- 3. When was your last varicella shot? _____
- 4. When was your last meningococcal shot? _____

Identified Problems:

- 1. _____
- 2. _____
- 3. _____

Review by Physician:

_____ No Athletic Participation
 _____ Limited Participation, e.g.: _____
 _____ Clearance Withheld Until: _____
 _____ Full Unlimited Participation

Athlete requesting clearance in the following sport(s): _____
 Cleared: Yes _____ No _____

Recommendations: _____ Na

me of Physician, NP or PA: _____

Address: _____ Phone: _____

Signature of Physician: _____, MD or DO Date: _____

(Physician's signature required if examination performed by nurse practitioner or physician's assistant)