

IHSAA PRE-PARTICIPATION PHYSICAL EVALUATION

SCHOOL:

HISTORY

Date: _____

Name: _____

Phone: (_____) _____

Address: _____

Zip: _____

Sex: _____ Age: _____ Date of Birth: _____

Grade: _____

Personal Physician: _____

Phone: (_____) _____

Previous school attended and dates: _____

Explain "Yes" answers below:

Yes No

1. Have you ever been hospitalized? _____

Have you ever had surgery? _____

2. Are you presently taking any medications or pills? _____

3. Do you have any allergies (medicine, bees or other stinging insects)? _____

4. Have you ever passed out during or after exercise? _____

Have you ever been dizzy during or after exercise? _____

Have you ever had chest pain during or after exercise? _____

Have you ever had high blood pressure? _____

Have you ever been told that you have a heart murmur? _____

Have you ever had racing of your heart or skipped heartbeats? _____

Has anyone in your family died of heart problems or a sudden death before age 50? _____

Has anyone in your family had Marfan's syndrome? _____

5. Do you have any skin problems (itching, rashes, acne)? _____

6. Have you ever had a head injury? _____

Have you ever been knocked out or unconscious? _____

Have you ever had a seizure, "fit" or epilepsy? _____

Have you ever had a stinger, burner or pinched nerve? _____

7. Have you ever had heat cramps, heat illness or muscle cramps? _____

8. Do you have trouble breathing or do you cough during or after activity? _____

9. Do you use any special equipment (pads, braces, neck rolls, eye guards, etc.)? _____

10. Have you had any problems with your eyes or vision? _____

Do you wear glasses or contacts or protective eye wear? _____

11. Are you missing an eye, kidney or testicle? _____

12. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints? _____

13. Have you had any other medical problems (infectious mononucleosis, diabetes, anemia, etc.)? _____

14. Have you had a medical problem or injury since your last evaluation? _____

15. When was your last tetanus shot? _____

16. When was your first menstrual period? _____

When was your last menstrual period? _____

What was the longest time between your periods last year? _____

Explain "Yes" answers:

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

Date: _____

Signature of athlete: _____

Signature of parent/guardian: _____

PHYSICAL EXAMINATION

Name: _____ Age: _____ Date of Birth: _____

Date: _____

Height: _____ Weight: _____ BP: _____ / _____ Pulse: _____
 Vision: R 20/____ L 20/____ Corrected: Y N Pupils (Circle) Equal/Unequal R > L L > R

Marfan's syndrome stigmata	No	Yes
Heart		
Rhythm	Regular	Irregular
Murmur (supine)	No	Yes
Murmur (standing)	No	Yes
Lungs		
Skin		
Abdominal		
Femoral Pulses		
Genitalia/Hernia		
Musculoskeletal:		
Neck		
Shoulders		
Elbows		
Wrists		
Hands		
Back		
Knees		
Ankles		
Feet		
Other		

Clearance:

- A. Cleared
- B. Cleared after completing evaluation/rehabilitation for:
- C. Not cleared

Due to: _____

Recommendation: _____

I hereby certify that this athlete was examined by me. At that time, no physical condition was detected which would reasonably be anticipated to render the athlete physically unfit to engage in any sport, except those marked below:

- Boys Sports: Baseball, Basketball, Cross Country, Football, Golf, Soccer, Swimming, Tennis, Track, Wrestling*
- Girls Sports: Basketball, Cross Country, Golf, Gymnastics, Soccer, Softball, Swimming, Tennis, Track, Volleyball

* Weight loss permitted to make lower weight class in Wrestling? Yes _____ No; If "Yes," may lose _____ pounds.

Name of Physician: _____

Address: _____

Phone: (____) _____

Date: _____

Signature of Physician: _____

(Based on recommendations developed by the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine and American Osteopathic Academy of Sports Medicine.)