Assets School
ANNUAL PHYSICAL EXAMINATION FOR ATHLETES

Student's Name (PRINT) _____ (LAST FIRST MIDDLE INITIAL) M/F _____ Date of Birth ____/____/____ (MONTH DAY YEAR)

Address _____ (STREET NO. CITY STATE ZIP CODE) Home Telephone _____ Grade _____

PHYSICAL EXAMINATION

Height _____ Weight _____ Blood Pressure _____/_____ Pulse _____

Vision: Right 20/ _____ Left 20/ _____ Corrected: Yes _____ No _____ Pupils _____

Immunization _____

	Normal	Comment	Initial
Cardiopulmonary			
Pulse			
Heart			
Lungs			
Abdominal			
E.N.T.			
Skin			
Genitalia			
Tanner Stage		1 2 3 4 5	
Musculoskeletal			
Neck			
Shoulder			
Elbow			
Wrist			
Hand			
Back			
Knee			
Ankle			
Foot			
Other			

Clearance:

A. Cleared

B. Cleared after completing evaluation/rehabilitation for _____

C. Not cleared for

- ☐ Collision
- ☐ Contact
- ☐ Noncontact ☐ Strenuous ☐ Moderately Strenuous ☐ Nonstrenuous

Due to _____

Physician's Recommendation _____

_____

_____

Name of Physician _____ Date _____

Address _____ Telephone _____

Signature of Physician _____ FAX No. _____

(Over)

PRE-PARTICIPATION PHYSICAL EVALUATION FORM
MEDICAL HISTORY DATA

Please explain "Yes" answers below.

	Yes	No
1. Have you 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 pains during or after exercise?	☐	☐
Do you tire more quickly than your friends during 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?	☐	☐
5. Do you have any skin problems (itching, rashes, acne)?	☐	☐
6. Have you ever been knocked out or unconscious?	☐	☐
Have you ever had a seizure?	☐	☐
Have you ever had a stinger burner or pinched nerve?	☐	☐
7. Have you ever had heat or muscle cramps?	☐	☐
Have you ever been dizzy or passed out in the heat?	☐	☐
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, mouth guard, eye guards, etc.)?	☐	☐
10. Have you ever had any problems with your eyes or vision?	☐	☐
Do you wear glasses or contacts or protective eye wear?	☐	☐
11. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints?	☐	☐

___ Ankle ___ Chest ___ Foot ___ Hand ___ Hip ___ Neck ___ Shoulder ___ Wrist

___ Back ___ Elbow ___ Forearm ___ Head ___ Knee ___ Shin/calf ___ Thigh

12. Have you had any other medical problems?	☐	☐

___ Mononucleosis ___ Rheumatic Fever ___ Pertussis ___ Tuberculosis ___ Chicken Pox

___ Other (describe) _____

_____

13. Have you had a medical problem or injury since your last evaluation?	☐	☐

14. When was your last tetanus shot? Month _____ Date _____ Year _____
15. When was your last measles immunization? Month _____ Date _____ Year _____
16. When was your first menstrual period? _____
17. When was your last menstrual period? _____
18. When was the longest time between your periods last year? _____

Explanation of any "Yes" answers:

_____

_____

_____

_____

I hereby verify to the best of my knowledge that the answers which have been provided to the above questions are correct.

Signature of Student _____ Date _____

Signature of Parent/Guardian _____ Date _____

Note: Please return this form to the Athletic Director after the physician has reviewed and completed the evaluation.