

# Assets School

## ANNUAL PHYSICAL EXAMINATION FOR ATHLETES

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

Address \_\_\_\_\_ Home Telephone \_\_\_\_\_ Grade \_\_\_\_\_  
STREET NO. CITY STATE ZIP CODE

### 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. \_\_\_\_\_

# PRE-PARTICIPATION PHYSICAL EVALUATION FORM

## MEDICAL HISTORY DATA

Please explain "Yes" answers below.

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 1. Have you been hospitalized? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had surgery? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you presently taking any medications or pills? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have any allergies (medicine, bees or other stinging insects)? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever passed out during or after exercise? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been dizzy during or after exercise? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had chest pains during or after exercise? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you tire more quickly than your friends during exercise? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had high blood pressure? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been told that you have a heart murmur? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had racing of your heart or skipped heartbeats? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Has anyone in your family died of heart problems or a sudden death before age 50? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any skin problems (itching, rashes, acne)? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever been knocked out or unconscious? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a seizure? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a stinger burner or pinched nerve? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had heat or muscle cramps? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been dizzy or passed out in the heat? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have trouble breathing or do you cough during or after activity? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever had any problems with your eyes or vision? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you wear glasses or contacts or protective eye wear? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| ___ Ankle    ___ Chest    ___ Foot    ___ Hand    ___ Hip    ___ Neck    ___ Shoulder    ___ Wrist  |                          |                          |
| ___ Back    ___ Elbow    ___ Forearm    ___ Head    ___ Knee    ___ Shin/calf    ___ Thigh  |                          |                          |
| 12. Have you had any other medical problems? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| ___ Mononucleosis    ___ Rheumatic Fever    ___ Pertussis    ___ Tuberculosis    ___ Chicken Pox  |                          |                          |
| ___ Other (describe) _____  |                          |                          |
| _____   |                          |                          |
| 13. Have you had a medical problem or injury since your last evaluation? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 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.