

BARTLESVILLE PUBLIC SCHOOLS
PRE-PARTICIPATION PHYSICAL EVALUATION

(PLEASE PRINT)

DATE OF EXAM:

Last Name :	First Name:	MI:	Date of Birth:
Height:	Weight:	Pulse:	BP: /

2017-2018 INFORMATION (please circle appropriate grade)

7 8 9 10 11 12

MEDICAL	NORMAL FINDINGS	ABNORMAL FINDINGS
Appearance		
Eyes/Ears/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Skin		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		

CLEARANCE

Cleared

Not cleared for: _____ Reason: _____

Recommendation(s): _____

Name & Title of Examiner (Printed): _____ Date: _____

Signature of Examiner: _____

ALL PHYSICALS MUST BE DATED AFTER MAY 1, 2017

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MEDICAL HISTORY

Name of Athlete (Print): _____

This section is to be carefully completed by the student and his/her parent(s) or legal guardian(s) before participation in interscholastic athletics in order to help detect possible risks.

Explain "YES" answers in the space provided. Circle questions you don't know the answer to.

	Yes	No		Yes	No
1 Has a doctor ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	25 Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
2 Do you have an ongoing medical condition (like diabetes or asthma)?	<input type="checkbox"/>	<input type="checkbox"/>	26 Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>
3 Are you currently taking any prescription or nonprescription (over-the-counter) medicine or pills?	<input type="checkbox"/>	<input type="checkbox"/>	27 Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>
4 Do you have allergies to medicines, pollens, foods or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>	28 Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
5 Do you think you are in good health?	<input type="checkbox"/>	<input type="checkbox"/>	29 Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
6 Have you ever passed out or nearly passed out DURING exercise?	<input type="checkbox"/>	<input type="checkbox"/>	30 Do you have any rashes, pressure sores or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
7 Have you ever passed out or nearly passed out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	31 Have you had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
8 Have you ever had discomfort, pain or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	32 Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
9 Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	33 Have you been hit in the head and been confused or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>
10 Has a doctor ever told you that you have (check all that apply):	<input type="checkbox"/>	<input type="checkbox"/>	34 Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> A heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	35 Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> High Cholesterol <input type="checkbox"/> A heart infection	<input type="checkbox"/>	<input type="checkbox"/>	36 Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
11 Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)	<input type="checkbox"/>	<input type="checkbox"/>	37 Have you ever been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
12 Has anyone in your family died for no apparent reason?	<input type="checkbox"/>	<input type="checkbox"/>	38 When exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>
13 Does anyone in your family have a heart problem?	<input type="checkbox"/>	<input type="checkbox"/>	39 Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
14 Has any family member or relative died of heart problems or sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	40 Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
15 Does anyone in your family have Marfan syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	41 Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
16 Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	42 Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
17 Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<u>FEMALES ONLY</u>		
18 Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis, that caused you to miss practice or game?	<input type="checkbox"/>	<input type="checkbox"/>	43 Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
19 Have you had any broken or fractured bones or dislocated joints?	<input type="checkbox"/>	<input type="checkbox"/>	44 How old were you when you had your first menstrual period?	_____	
20 Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast or crutches? If yes, circle below:	<input type="checkbox"/>	<input type="checkbox"/>	45 How many periods have you had in the last 12 months?	_____	
Head Neck Shoulder Chest Elbow Knee					
Forearm Hand/Finger Hip Thigh Calf/Shin					
Upper Back Ankle/Foot Upper Arm Lower Back					
21 Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>			
22 Have you been told that you have or have you had an x-ray for neck instability?	<input type="checkbox"/>	<input type="checkbox"/>			
23 Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>			
24 Has a doctor told you that you have asthma or allergies?	<input type="checkbox"/>	<input type="checkbox"/>			

Explain "Yes" Answers here: (Attach additional sheets as needed):

I (we) hereby state, to the best of my (our) knowledge, my (our) answers to the above questions are complete and correct:

Signature: _____ Date: _____

(Parent and/or Guardian)