BARTLESVILLE PUBLIC SCHOOLS
PRE-PARTICIPATION PHYSICAL EVALUATION

DATE OF EXAM:

(PLEASE PRINT)

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

2016-2017 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, 2016

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
1 Has a doctor ever denied or restricted your participation in sports for any reason?	❑	❑
2 Do you have an ongoing medical condition (like diabetes or asthma)?	❑	❑
3 Are you currently taking any prescription or nonprescription (over-the- counter) medicine or pills?	❑	❑
4 Do you have allergies to medicines, pollens, foods or stinging insects?	❑	❑
5 Do you think you are in good health?	❑	❑
6 Have you ever passed out or nearly passed out DURING exercise?	❑	❑
7 Have you ever passed out or nearly passed out AFTER exercise?	❑	❑
8 Have you ever had discomfort, pain or pressure in your chest during exercise?	❑	❑
9 Does your heart race or skip beats during exercise?	❑	❑
10 Has a doctor ever told you that you have (check all that apply):	❑	❑
❑ High Blood Pressure ❑ A heart murmur	❑	❑
❑ High Cholesterol ❑ A heart infection	❑	❑
11 Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)	❑	❑
12 Has anyone in your family died for no apparent reason?	❑	❑
13 Does anyone in your family have a heart problem?	❑	❑
14 Has any family member or relative died of heart problems or sudden death before age 50?	❑	❑
15 Does anyone in your family have Marfan syndrome?	❑	❑
16 Have you ever spent the night in a hospital?	❑	❑
17 Have you ever had surgery?	❑	❑
18 Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis, that caused you to miss practice or game?	❑	❑
19 Have you had any broken or fractured bones or dislocated joints?	❑	❑
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:	❑	❑
Head Neck Shoulder Chest Elbow Knee Forearm Hand/Finger Hip Thigh Calf/Shin Upper Back Ankle/Foot Upper Arm Lower Back		
21Have you ever had a stress fracture?	❑	❑
22 Have you been told that you have or have you had an x-ray for for neck instability?	❑	❑
23 Do you regularly use a brace or assistive device?	❑	❑
24 Has a doctor told you that you have asthma or allergies?	❑	❑

	Yes	No
25 Do you cough, wheeze, or have difficulty breathing during or after exercise?	❑	❑
26 Is there anyone in your family who has asthma?	❑	❑
27 Have you ever used an inhaler or taken asthma medicine?	❑	❑
28 Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	❑	❑
29 Have you had infectious mononucleosis (mono) within the last month?	❑	❑
30 Do you have any rashes, pressure sores or other skin problems?	❑	❑
31 Have you had a herpes skin infection?	❑	❑
32 Have you ever had a head injury or concussion?	❑	❑
33 Have you been hit in the head and been confused or lost your memory?	❑	❑
34 Have you ever had a seizure?	❑	❑
35 Do you have headaches with exercise?	❑	❑
36 Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	❑	❑
37 Have you ever been unable to move your arms or legs after being hit or falling?	❑	❑
38 When exercising in the heat, do you have severe muscle cramps or become ill?	❑	❑
39 Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	❑	❑
40 Have you had any problems with your eyes or vision?	❑	❑
41 Do you wear glasses or contact lenses?	❑	❑
42 Do you wear protective eyewear, such as goggles or a face shield?	❑	❑

FEMALES ONLY

43 Have you ever had a menstrual period?	❑	❑
44 How old were you when you had your first menstrual period?		
45 How many periods have you had in the last 12 months?		

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)