

GREENBRIER SCHOOL DISTRICT PHYSICAL EVALUATION

Page 1 – To be completed by student and/or guardian

Name _____ Sex ____ Age ____ Grade _____ Date of Birth _____

Parent's Name _____ Phone _____

Physician's Name _____ Phone _____

1. Have you ever been hospitalized? __Yes __No
2. Have you ever had surgery? __Yes __No
3. Are you presently taking any medications or pills? __Yes __No
4. Do you have any allergies (medicine, bees or other stinging insects?) __Yes __No
5. Have you ever passed out during or after exercise? __Yes __No
6. Have you ever been dizzy during or after exercise? __Yes __No
7. Do you tire more quickly than your friends during exercise? __Yes __No
8. Have you ever had high blood pressure? __Yes __No
9. Have you ever been told that you have a heart murmur? __Yes __No
10. Have you ever had racing of your heart or skipped heartbeats? __Yes __No
11. Has anyone in your family died of heart problems or a sudden death before age 50? __Yes __No
12. Do you have any skin problems (itching, rashes, acne)? __Yes __No
13. Have you ever had a head injury? __Yes __No
14. Have you ever been knocked out or unconscious? __Yes __No
15. Have you ever had a seizure? __Yes __No
16. Have you ever had a stinger, burner or pinched nerve? __Yes __No
17. Have you ever had heat or muscle cramps? __Yes __No
18. Have you ever been dizzy or passed out in the heat? __Yes __No
19. Do you have trouble breathing or do you cough during or after activity? __Yes __No
20. Do you use any special equipment (pads, braces, neck rolls, mouth guards, eye guards, etc.)? __Yes __No
21. Have you ever had any problems with your eyes or vision? __Yes __No
22. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints? __Yes __No
 __Head __Shoulder __Thigh __Neck __Elbow
 __Knee __Chest __Foot __Forearm __Shin/Calf
 __Back __Wrist __Ankle __Hip __Hand
23. Have you had any other medical problems (infectious mononucleosis, diabetes, etc.)? __Yes __No
24. Have you had a medical problem or injury since your last evaluation? __Yes __No
25. When was your last tetanus shot?
26. When was your last measles immunization?
27. When was your first menstrual period?
28. When was your last menstrual period?
29. What was the longest time between your periods last year?

Explain any "Yes" answers here:

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 _____

■ PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

EXAMINATION		
Height:	Weight:	
BP: / (/)	Pulse:	Vision: R 20/ L 20/ Corrected: <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal, hearing		
Lymph nodes		
Heart* • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), ortinea corporis		
Neurological		
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

*Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings

- Cleared for all sports without restriction
- Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

- Not cleared
- Pending further evaluation
 - For any sports
 - For certain sports _____

Reason: _____

Recommendations: _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of provider: _____ Date of exam: _____

Address: _____ Phone: _____

Signature of physician, APN, PA: _____