HCAA PHYSICAL EXAMINATION FORM
ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION FORM
Part A: HEALTH HISTORY QUESTIONNAIRE
(To be completed by the parent and student)

Today's Date:_____ **Date of Last Physical: _____**

Student's Name: _____ Sex: M F (circle one) Age: _____

Date of Birth: _____ Sport: _____ Home Phone: _____

Grade: _____ School: _____ District: _____

Physician: _____ Phone: _____ Fax: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to student: _____
Phone (work): _____ Phone (home):_____ Phone (cell): _____

Directions: Please answer the following questions about the student's medical history. Explain all "yes" responses at the bottom of the page. Please respond to all questions.

1. Have you had or do you currently have:

a. A sports physical within the past 365 days?	Y / N / Don't Know
b. An injury or illness since your last exam?	Y / N / Don't Know
c. A chronic or ongoing illness (such as diabetes or asthma)?	Y / N / Don't Know
1. Use an inhaler or other prescription medicine to control asthma?	Y / N / Don't Know
d. Any prescribed or over the counter medications that you take on a regular basis?	Y / N / Don't Know
e. Surgery, hospitalization or any emergency room visit(s)?	Y / N / Don't Know
f. Any allergies to medications?	Y / N / Don't Know
g. Any allergies to bee stings, pollen, latex or foods?	Y / N / Don't Know
1. Type of reaction: Rash? Hives? Other skin condition? (Circle all that apply.)	Y / N / Don't Know
2. Take any medication/Epipen taken for allergy symptoms? (List below.)	Y / N / Don't Know
h. Any anemias or blood disorders?	Y / N / Don't Know

2. Have you had or do you currently have any of the following *head-related* conditions since your last physical:

a. Concussion requiring a physician's evaluation?	Y / N / Don't Know
1. How often and when? (Answer below.)	
b. Memory loss or been knocked out?	Y / N / Don't Know
c. A seizure?	Y / N / Don't Know
d. Frequent or severe headaches?	Y / N / Don't Know

3. Have you had or do you curently have any of the following *heart-related* conditions since your last physical:

a. Chest pain?	Y / N / Don't Know
b. Heart murmur?	Y / N / Don't Know
c. High blood pressure or elevated cholesterol level?	Y / N / Don't Know
d. Restriction from sports for heart problems?	Y / N / Don't Know
e. Any family member or relative:	
1. Die of a heart problem before age 35?	Y / N / Don't Know
2. Die of a heart problem before age 50?	Y / N / Don't Know
3. Die with no known reason?	Y / N / Don't Know
4 Die while exercising? During or after? (Circle one.)	Y / N / Don't Know
5. With Marfan's Syndrome?	Y / N / Don't Know

4. Have you had or do you currently have any of the following *eye, ear, nose, mouth or throat conditions* since your last physical:

a. Vision problems?	Y / N / Don't Know
1. Wear contacts, eyeglasses or protective eye wear? (Circle which type.)	Y / N / Don't Know
b. Hearing loss or problems?	Y / N / Don't Know
1. Wear hearing aides or implants?	Y / N / Don't Know
c. Nasal fractures or frequent nose bleeds?	Y / N / Don't Know
d. Wear braces, retainer or protective mouth gear?	Y / N / Don't Know
e. Frequent strep or any other conditions of the throat (e.g. tonsillitis)?	Y / N / Don't Know

5. Have you had or do you currently have any of the following *neuromuscular/orthopedic conditions* since your last physical:

a. A burner, stinger or pinched nerve?	Y / N / Don't Know
b. A sprain?	Y / N / Don't Know
c. A strain?	Y / N / Don't Know
d. Swelling or pain in muscles, tendons, bones or joints?	Y / N / Don't Know
e. A dislocated joint(s)?	Y / N / Don't Know
f. Upper or lower back pain?	Y / N / Don't Know
g. Fracture(s) or stress fracture(s)?	Y / N / Don't Know
h. Do you wear any protective braces or equipment for any prior injury?	Y / N / Don't Know

6. Have you had or do you currently have any of the following *general or exercise related conditions* since your last physical:

a. Difficulty breathing? During Exercise? (Circle one.)	
1. After running one mile	Y / N / Don't Know
2. Coughing, wheezing or shortness of breathe in weather changes?	Y / N / Don't Know
3. Exercise-induced asthma	Y / N / Don't Know
i. Controlled with medication? (List below.)	Y / N / Don't Know
ii. Experience dizziness, passing out or fainting?	Y / N / Don't Know
b. Viral infections (e.g. mono, hepatitis)?	Y / N / Don't Know
c. Become tired more quickly than your friends?	Y / N / Don't Know
d. Any of the following skin conditions:	
1. Acne, contact dermatitis, ringworm, warts, herpes?	Y / N / Don't Know
2. Sun sensitivity?	Y / N / Don't Know
e. Weight gain/loss (greater than or less than 10 pounds)?	Y / N / Don't Know
1. Do you want to weigh more or less than you do now?	Y / N / Don't Know
f. Ever had feelings of depression?	Y / N / Don't Know
g. Heat-related problems (dehydration, dizziness, fatigue, headache)?	Y / N / Don't Know
1. Heat exhaustion (cool, clammy, damp skin)?	Y / N / Don't Know
2. Heat stroke (hot, red, dry skin)?	Y / N / Don't Know

7. **Females only:**

Age of onset of menstruation:_____

Date of last menstruation:_____

Most number of days between menstruation cycle(s):_____

Explain all (yes) answers here (include relevant dates):

_____
_____
_____
_____
_____
_____
_____
_____

I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature.

Parent/Guardian Signature:_____ Date:_____

HCAA PHYSICAL EVALUATION FORM

(To be completed by the examining physician)

Examination Date: _____

-STUDENT INFORMATION-

Student's Name: _____ Sport: _____
Sex: M F (circle one) Age: _____ Grade: _____ Date of Birth: _____
Address: _____
City/State/Zip:_____ Home Phone: _____
School: _____ District: _____
Parent/Guardian's Full Name: _____

-PHYSICIAN INFORMATION-

Name: _____ Phone: _____ Fax: _____

Address: _____ City/State/Zip:_____

PHYSICIAN OR PROVIDER INFORMATION – PLEASE COMPLETE BOTH PAGES

Height: _____ Weight: _____ Blood Pressure: _____/_____ Pulse: _____bpm.

Vision: R 20/____ L 20/ ____ Corrected: Y / N Contacts: Y / N Glasses: Y / N

Indicators	Normal? (Circle One)		Abnormal Findings/Comments
Head/Neck	YES	NO	
Eyes/Sclera/Pupils	YES	NO	
Ears	YES	NO	
Nose/Mouth/Throat	YES	NO	
Heart: Murmurs/Rhythms	YES	NO	
Lungs: Auscultation/Percussion	YES	NO	
Chest Contour	YES	NO	
Skin	YES	NO	
Abdomen: Assessment (incl. liver, spleen)	YES	NO	
Tanner Stage: Testes/Onset of Menses:	YES	NO	
Neck/Back/Spine: Range of Motion:	YES YES	NO NO	
Scoliosis:	YES	NO	
Upper Extremities:	YES	NO	
Lower Extremities:	YES	NO	
Neurological: Balance & Coordination: Romberg:	 YES YES	 NO NO	
Heel Walk:	YES	NO	
Tandem Walk:	YES	NO	
Nose Touch:	YES	NO	
Toe Walk:	YES	NO	
Hernia? (if yes/possible, please explain)	YES/ Possible	NO	

Most recent immunizations/Dates:
Medications currently being used:
Additional Observations:

General Diagnosis: _____
Recommendations: _____

CLEARANCES

A. Student MAY participate in the following sports: (CHECK ALL THAT APPLY)

___ CONTACT/COLLISION **___ NON-CONTACT/STRENUOUS**
___ LIMITED CONTACT **___ NON-CONTACT/NON-STRENUOUS**

SAMPLES OF CLASSIFICATION OF SPORTS BY CONTACT			
Contact/Collision	**Limited Contact**	**Non-Contact**	
		Strenuous	**Non-strenuous**
Field Hockey	Baseball	Discus	Bowling
Football	Basketball	Javelin	Golf
Ice Hockey	Cheerleading	Shot put	
Lacrosse	Diving	Rowing	
Soccer	Fencing	Running/Cross Country	
Wrestling	Field	Strength Training	
	High Jump	Swimming	
	Pole vault	Tennis	
	Gymnastics	Track	
	Skiing		
	Softball		
	Volleyball		

B. Student MAY participate in following sport(s) ONLY AFTER completing evaluation/rehabilitation: (CHECK ALL THE APPLY)

___ CONTACT/COLLISION **___ NON-CONTACT/STRENUOUS**
___ LIMITED CONTACT **___ NON-CONTACT/NON-STRENUOUS**

Please specify each condition requiring clearance before participating in a sport in the classification checked above:
_____
_____

Conditions requiring clearance before sports participation include, but are not limited to: *Atlantoaxial instability; Bleeding disorder; Hypertension;Congenital heart disease; Dysrhythmia; Mitral valve prolapse; Heart murmur; Cerebral palsy; Diabetes mellitus; Eating disorders; Heat illness history; One-kidney athletes; Hepatomegaly, Splenomegaly; Malignancy; History of repeated concussion; Organ transplant recipient; Cystic fibrosis; Sickle cell disease; and/or One-eyed athletes or athletes with vision greater than 20/40 in one eye.*

Physician's/Provider's Stamp:

EXAMINED BY:
Family Physician/Provider_____
School Physician_____

____MD ____DO____NP____PA

Physician's/Provider's Signature: _____ Date: _____