PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

lame:(First Name) ate of examination:	(Last Name)	8) before your appointme Date of bi		
ate of examination:				
ex assigned at birth:				
List past and current medical conditions				
Have you ever had surgery? If yes, list all past surgio	cal procedures			
Medicines and supplements: List all current prescrip	otions, over-the-co	unter medicines, and supp	lements (herbal and nutr	ritional).
Do you have any allergies? If yes, please list all you	ur allergies (ie, me	dicines, pollens, food, stin	ging insects).	
Patient Health Questionnaire Version 4 (PHQ-4) Over the last 2 weeks, how often have you been be	othered by any of Not at all		heck box next to appropri	
Feeling nervous, anxious, or on edge				
Not being able to stop or control worrying				
Little interest or pleasure in doing things	0	□ 1		
Feeling down, depressed, or hopeless				
cerning down, depressed, or nopeless	□0		2	13
	The state of the s		and 4] for screening pur	
(A sum of ≥3 is considered positive on either	The state of the s			
(A sum of ≥3 is considered positive on either GENERAL QUESTIONS	The state of the s	ns 1 and 2, or questions 3 HEART HEALTH QUESTIONS	and 4] for screening pur	rposes.)
(A sum of ≥3 is considered positive on either GENERAL QUESTIONS (Explain "Yes" answers at the end of this form.	subscale [question	ns 1 and 2, or questions 3 HEART HEALTH QUESTIONS (CONTINUED)	and 4] for screening pur	
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BONE AND JOINT QUESTIONS	Yes	No	MEDICAL QUESTIONS (CONTINUED)	Yes	No
14. Have you ever had a stress fracture or an injury			25. Do you worry about your weight?		
to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?	Ш	Ш	26. Are you trying to or has anyone recommended that you gain or lose weight?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?			27. Are you on a special diet or do you avoid certain types of foods or food groups?		
MEDICAL QUESTIONS	Yes	No	28. Have you ever had an eating disorder?		
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?			FEMALES ONLY 29. Have you ever had a menstrual period?	Yes	No
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?			30. How old were you when you had your first menstrual period?		
. 18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?			31. When was your most recent menstrual period?		
19. Do you have any recurring skin rashes or			32. How many periods have you had in the past 12 months?		
rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?			Explain "Yes" answers here.		
Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?					
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?					
22. Have you ever become ill while exercising in the heat?					
23. Do you or does someone in your family have sickle cell trait or disease?					
24. Have you ever had or do you have any prob- lems with your eyes or vision?					
I hereby state that, to the best of my known and correct. Signature of athlete: Signature of parent or guardian: Date:				omple	te

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2022 This form has been modified for use by the GHSA

PREPARTICIPATION PHYSICAL EVALUATION

ame:	(First Name)	(Last Name)	Date	of birth:			
YSICIAN REMIN		(Last Name)					
	itional questions on more-sensi	tive issues					
	el stressed out or under a lot of						
	er feel sad, hopeless, depresse						
 Do you fee 	el safe at your home or residen	ice?					
Have you	ever tried cigarettes, e-cigarett	es, chewing tobacco, snuff, or di	oś				
During the	past 30 days, did you use che	ewing tobacco, snuff, or dip?					
Do you dri Have your	ink alcohol or use any other dr	rugs?					
Have you e	ever taken anabolic steroids of	rused any other performance-enl help you gain or lose weight or i	nancing supplements				
Do you we	ear a seat belt, use a helmet, a	nd use condoms?	mprove your perform	nances			
		ular symptoms (Q4–Q13 of Histo	ry Form)				
XAMINATION							
leight:	Weight:						
P: /	(/) Pulse:	Vision: R 20/	L 20/	C	Пу		
MEDICAL	1 / I lose.	VISIOII. R 20/	L 20/	Corrected	Charles and Confession		- INIOINIO
ppearance				L	ORMAL	ABNORMALI	TINDINGS
	ita (kyphoscoliosis, high-arche	d palate, pectus excavatum, arac	handactily hyporlay	db.			
myopia, mitral	valve prolapse [MVP], and a	ortic insufficiency)	illoddciyly, flyperid	diy,			
yes, ears, nose, c							
Pupils equal							
Hearing							
ymph nodes							
leart ^a					一		
Murmurs (auso	ultation standing, auscultation	supine, and ± Valsalva maneuve	er)				
ungs							
bdomen							
kin							
Herpes simples	x virus (HSV), lesions suggestiv	ve of methicillin-resistant Staphylo	coccus aureus (MRS	A), or			
tinea corporis					Ш		
Neurological							
MUSCULOSKELET	AL			 N	ORMAL	ABNORMAL	FINDINGS
leck							
ack							
houlder and arm							
lbow and forearr	m						
Vrist, hand, and	fingers						
tip and thigh							VENEZIO I
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eg and ankle							
oot and toes							
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PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Date of birth: Name: ___ Medically eligible for all sports without restriction Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of Medically eligible for certain sports ☐ Not medically eligible pending further evaluation ☐ Not medically eligible for any sports Recommendations: I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians). Name of health care professional (print or type): _______ Date: _____ _____ Phone: ____ Signature of health care professional: , MD, DO, NP, or PA SHARED EMERGENCY INFORMATION Allergies: Medications: ___ Other information: Emergency contacts: ____

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