

MT. VIEW JUNIOR AND SENIOR HIGH SCHOOL Pre-participation Physical Evaluation

History (To be filled out by student & parent/guardian)

Date: _____

Name: _____ Sex: _____ Age: _____ Date of Birth: _____

Grade: _____ Sport: _____

Address: _____ Phone: _____

Explain "Yes" answers below:

	Yes	No
1. Have you ever been hospitalized?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery?.....	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you presently taking any medications or pills?.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have any allergies (medicine, bees, or other stinging insects)?.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever passed out during or after exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been dizzy during or after exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had chest pain during or after exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you tire more quickly than your friends during exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had high blood pressure?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been told that you have a heart murmur?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had racing of your heart or skipped heart beats?.....	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone in your family died of heart problems or a sudden death before age 50?.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any skin problems (itching, rashes, acne)?.....	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had a head injury?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been knocked out or unconscious?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a seizure?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a stinger, burner or pinched nerve?.....	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had heat or muscle cramps?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been dizzy or passed out in the heat?.....	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have trouble breathing or do you cough during or after activity?.....	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you use any special equipment (pads, braces, neck rolls, mouth guards, eye guards, etc.).....	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you had any problems with your eyes or vision?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear glasses or contacts or protective eye wear?.....	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling of any bones or joints?.....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Head <input type="checkbox"/> Shoulder <input type="checkbox"/> Thigh <input type="checkbox"/> Neck <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Chest <input type="checkbox"/> Foot		
<input type="checkbox"/> Forearm <input type="checkbox"/> Shin/calf <input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Ankle <input type="checkbox"/> Hip <input type="checkbox"/> Hand		
12. Have you had any other medical problems (infectious mononucleosis, diabetes, etc.)?.....	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you had any medical problem or injury since your last evaluation?.....	<input type="checkbox"/>	<input type="checkbox"/>
14. When was you last tetanus shot? _____		
When was your last measles immunization? _____		
15. When was your first menstrual period? _____		
When was your last menstrual period? _____		
What was the longest time between your periods last year? _____		

Explain "Yes" answers (use additional paper if needed):

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: _____

Physical Examination (To be completed by physician)

Date: _____

Name: _____ Age: _____ Date of Birth: _____

Complete	Limited	Height: _____ Weight: _____ BP: _____ / _____ Pulse: _____			
		Vision: R 20/ _____ L 20/ _____ Corrected: Y N Pupils _____			
			Normal	Abnormal Findings	Initials
		Cardiopulmonary			
		Pulses			
		Heart			
		Lungs			
		Tanner Stage			
	Skin				
	Neurological				
	Abdominal				
	Genitalia				
	Musculoskeletal				
	Neck				
	Shoulder				
	Elbow				
	Wrist				
	Hand				
	Back				
	Knee				
Ankle					
Foot					
Other					

Immunizations given today: _____

Clearance: (Please circle correct response)

- A. Cleared for Athletic Participation
- B. Not Cleared
- C. Cleared after completing evaluation/rehabilitation for: _____
- D. Cleared for: * Non-contact Non-strenuous

* Restriction due to: _____

Recommendations/Restrictions: _____

Name of Physician: _____ Date: _____

Address: _____ Phone: _____

Signature of Physician: _____