Preparticipation Physical Evaluation

MEMORIAL HOSPITAL of Converse County
Advanced Medicine. Hometown Care.

Date of Exam: _____

Name:	Sex:	Age:	Date of Birth:
Grade: School:	Sports:		
Address:			Phone:
Personal Physician:			
In Case of Emergency, Contact:			
Work Phone:	Home Phone:		Relationship:

Explain "Yes" answers below. Circle questions if you are not sure of the answer.

	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 over the counter medicines, inhaler, or pills?	☐	☐
If so, please list: _____		
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐
5. Have you ever passed out or nearly passed out DURING exercise?	☐	☐
6. Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
8. Does your heart race or skip beats during exercise?	☐	☐
9. Has a doctor ever ordered a test for your heart? (For example, ECG, echocardiogram)	☐	☐
10. Have you ever had a stress fracture?	☐	☐
11. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
12. Do you regularly use an orthopaedic brace or assistive device or have frequent pain or weakness in your bones or joints?	☐	☐
13. Has a doctor ever told you that you have asthma?	☐	☐
14. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
15. Have you ever used an inhaler or taken asthma medicine?	☐	☐
16. Have you had infectious mononucleosis (mono) within the last month?	☐	☐
17. Have you had a head injury or concussion in the last year?	☐	☐
18. Have you ever had a seizure?	☐	☐
19. Do you have headaches with exercise?	☐	☐
20. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
21. When exercising in the heat, do you have severe muscle cramps or become ill or have had a heat stroke?	☐	☐
22. Has a doctor told you that you or someone in your family has the sickle cell trait or sickle cell disease or bleeding problems?	☐	☐
23. Have you had any problems with your eyes or vision other than corrective lenses?	☐	☐
24. Do you have any concerns that you would like to discuss with a doctor?	☐	☐
If so, please list: _____	☐	☐
25. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
26. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
27. Have you had a herpes skin infection?	☐	☐
Females Only:		
28. Do you have regular menstrual periods?	☐	☐
29. Are you having irregular, painful, or missed periods?	☐	☐

Explain "Yes" answers here: _____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Athlete: _____ Date: _____ **(required)**

Signature of Parent/Guardian: _____ Date: _____ **(required)**

Physical Examination Form

Date of Exam: _____

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Name:		Grade:	Date of Birth:
Height:	Weight:	BMI:	
Pulse:		BP: /	
Vision: R20/	L20/	Corrected: Y N	Pupils: Equal Unequal

	Normal	Abnormal Findings	Initials
Medical			
Appearance			
Eyes/Ears/Nose/Throat			
Hearing			
Lymph Nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Skin			
Musculoskeletal			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand/Fingers			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			

☐ **Cleared** ☐ **Not Cleared. Reason:** _____

Allergies: _____

Epipen ☐ Epilepsy ☐ Asthma ☐

Diabetes ☐ Other Chronic Health Issue _____

Recommendations/Restrictions: _____

Name of Physician (print): **Date:**

Signature of Physician:

PARENT/GUARDIAN CONSENT FOR EMERGENCY MEDICAL ASSISTANCE

I hereby authorize Converse County School District #1 and its faculty members in charge of my child named below to obtain all necessary medical care for my child in the event that I cannot be reached to authorize it myself. I hereby authorize any licensed physician and/or medical personnel to render necessary medical treatment to my child.

Student's Name: _____ Father's Name: _____

Address: _____ Mother's Name: _____

_____

Date: _____ Signature of Parent/Guardian: _____

Work Phone Numbers: Father's: _____ Home Phone: _____

Mother's: _____

INSURANCE (Parent/Guardian please check one statement)

Insurance is mandatory for anyone participating in athletics and/or cheerleading. Converse County School District #1 does not carry insurance for students.

_____ This is to inform you that my child listed above is not covered by an accident insurance policy and that I wish to purchase insurance.
*Student insurance is available through a local carrier and forms can be obtained at the Athletic office.

_____Football Only _____School Accident Only _____Both

_____ This is to inform you that my child listed above is covered by an accident insurance policy, that the policy will remain in effect during all activities that my child is involved in, and I do not wish to purchase additional insurance.

Insurance Information: Company: _____

Policy Number: _____

Signature of Parent/Guardian: