

Preparticipation Physical Evaluation PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

- Consider additional questions on more sensitive issues
 - Do you feel stressed out or under a lot of pressure?
 - Do you ever feel sad, hopeless, depressed, or anxious?
 - Do you feel safe at your home or residence?
 - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
 - During the past 30 days, did you use chewing tobacco, snuff, or dip?
 - Do you drink alcohol or use any other drugs?
 - Have you ever taken anabolic steroids or used any other performance supplement?
 - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
 - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (questions 5-14).

EXAMINATION		□ Male □ Female	
Height	Weight		
BP / / (/)	Pulse	Vision R 20/	L 20/
		Corrected	□ Y □ N
MEDICAL	NORMAL	ABNORMAL FINDINGS	
Appearance - Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)			
Eyes/ears/nose/throat - Pupils equal - Hearing			
Lymph nodes			
Heart* - Murmurs (auscultation standing, supine, +/- Valsalva) - Location of point of maximal impulse (PMI)			
Pulses - Simultaneous femoral and radial pulses			
Lungs			
Abdomen			
Genitourinary (males only) ^g			
Skin - HSV, lesions suggestive of MRSA, tinea corporis			
Neurologic ^h			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			
Functional - Duck-walk, single leg hop			

*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
^gConsider GU exam if in private setting. Having third party present is recommended.
^hConsider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

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. A copy of the physical exam is 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 clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____
 Address _____ Phone _____
 Signature of physician _____, MD or DO

Preparticipation Physical Evaluation

CLEARANCE FORM- THIS ALONG WITH ANY LIFE THREATING OR ONGOING MEDICAL CONDITIONS SHOULD BE SHARED WITH THE SCHOOL

Name _____ Sex M F Age _____ Date of birth _____

Date of Exam _____

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. A copy of the physical exam is 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 clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____ MD or DO

EMERGENCY INFORMATION

Allergies _____

Other information _____

