

# IHSAA PRE-PARTICIPATION PHYSICAL EVALUATION

SCHOOL: \_\_\_\_\_

## HISTORY

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Personal Physician: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Previous school attended and dates: \_\_\_\_\_

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"/> |
| Are you presently under a doctor's care? .....   | <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"/> |
| 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 heartbeats? .....  | <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"/> |
| Has anyone in your family had Marfan's syndrome? .....   | <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 or epilepsy? .....   | <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 cramps, heat illness or muscle cramps? .....   | <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, 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. Are you missing an eye, kidney or testicle? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries 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"/> 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 |                          |                          |
| 13. Have you had any other medical problems (infectious mononucleosis, diabetes, anemia, etc.)? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. <b>Have you had a medical problem or injury since your last evaluation?</b> .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. When was your last tetanus shot? _____   |                          |                          |
| 16. 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:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

Date: \_\_\_\_\_ Signature of athlete: \_\_\_\_\_

Date: \_\_\_\_\_ Signature of parent/guardian: \_\_\_\_\_

# PHYSICAL EXAMINATION

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BP: \_\_\_\_\_/\_\_\_\_\_ Pulse: \_\_\_\_\_

Vision: R 20/\_\_\_\_\_ L 20/\_\_\_\_\_ Corrected: Y N Pupils (Circle) Equal/Unequal R > L L > R

	Circle (if option given)	Specific Findings
Marfan's syndrome stigmata	No Yes	
<b>Heart</b>		
Rhythm	Regular Irregular	
Murmur (supine)	No Yes	
Murmur (standing)	No Yes	
	Normal <input type="checkbox"/>	Specific Findings
Lungs		
Skin		
Abdominal		
Femoral Pulses		
Genitalia/Hernia		
<b>Musculoskeletal:</b>		
Neck		
Shoulders		
Elbows		
Wrists		
Hands		
Back		
Knees		
Ankles		
Feet		
Other		

Clearance:

- A. Cleared
  - B. Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_
  - C. Not cleared
- Due to: \_\_\_\_\_

Recommendation: \_\_\_\_\_

I hereby certify that this athlete was examined by me. At that time, no physical condition was detected which would reasonably be anticipated to render this athlete physically unfit to engage in any sport, **except those marked below:**

**Boys Sports:** Baseball, Basketball, Cross Country, Football, Golf, Soccer, Swimming, Tennis, Track, Wrestling

**Girls Sports:** Basketball, Cross Country, Golf, Gymnastics, Soccer, Softball, Swimming, Tennis, Track, Volleyball

Name of Physician: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_

Signature of Physician: \_\_\_\_\_

*(Based on recommendations developed by the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine and American Osteopathic Academy of Sports Medicine.)*