Pre-Participation Physical Evaluation

Student's Name:_____ ID #_____ School:_____ Date of Exam: _____

Gender: M____ F____ Age:_____ DOB:_____ **Class** : **20** Sport(s): _____

Home Address:_____ Phone:_____

Personal Physician's Name: _____

Emergency Contact: Name_____

Relationship:_____ Phone: Home_____ Work _____

Check **YES** or **NO** for questions below and **explain any "yes" answers**. **Circle** questions you don't know the answers to.

	YES	**NO**
1. Have you had a medical illness or injury since your last check up or sports physical?	☐	☐
Do you have an ongoing or chronic illness?	☐	☐
2. Have you ever been hospitalized overnight?	☐	☐
Have you ever had surgery?	☐	☐
3. Are you currently taking any prescription or nonprescription medications or using an inhaler?	☐	☐
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	☐	☐
4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	☐	☐
Have you ever had a rash or hives develop during or after exercise?	☐	☐
5. Have you ever passed out or been dizzy during or after exercise?	☐	☐
Have you ever had chest pain during or after exercise?	☐	☐
Do you get tired more quickly than your friends do during exercise?	☐	☐
Have you ever had racing of your heart or skipped heartbeats?	☐	☐
Have you ever had high blood pressure or high cholesterol?	☐	☐
Have you ever been told you have a heart murmur?	☐	☐
Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	☐	☐
Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐
6. Do you have any current skin problems (itching, rashes, acne, warts, fungus, or blisters, etc.)?	☐	☐
7. Have you ever had a head injury or concussion?	☐	☐
Have you ever been knocked out, become unconscious or lost your memory?	☐	☐
Have you ever had a seizure?	☐	☐
Do you have frequent or severe headaches?	☐	☐
Have you ever had numbness or tingling in your arms, hands, legs, or feet?	☐	☐
8. Have you ever become ill from exercising in the heat?	☐	☐
9. Do you cough, wheeze, or have trouble breathing during or after an activity?	☐	☐
Do you have asthma or seasonal allergies that require medical treatment?	☐	☐
10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aids, etc.)?	☐	☐
11. Do you wear glasses, contacts, or protective eyewear?	☐	☐
12. Have you ever had a sprain, strain, or swelling after an injury?	☐	☐
Have you broken or fractured any bones or dislocated any joints?	☐	☐
Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	☐	☐
If ***yes***, check the appropriate box and explain below:		
☐ Head ☐ Neck ☐ Back ☐ Chest ☐ Shoulder ☐ Upper Arm ☐ Elbow		
☐ Forearm ☐ Wrist ☐ Hand ☐ Finger ☐ Hip ☐ Thigh ☐ Knee		
☐ Shin/Calf ☐ Ankle ☐ Foot		
13. Do you want to weigh more or less than you do now?	☐	☐
Do you lose weight regularly to meet weight requirements for your sport?	☐	☐
14. Record the dates of most recent immunizations: Tetanus: Chickenpox: Measles: Hepatitis B:		
15. **For Females Only**: When was your first menstrual period? _____		
When was your most recent menstrual period? How many days between periods?		
16. Have you ever tested positive or been diagnosed with COVID-19? If yes, when? **YES**____ **NO**____ Date positive/diagnosis_____		

Please explain any "YES" answers on the other side of this form

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

Athlete's Signature: _____ **Parent's Signature:**_____ **Date:** _____

HUNTINGTON BEACH UNION HIGH SCHOOL DISTRICT

Pre-Participation Physical Evaluation

PHYSICAL EXAMINATION

Student's Name:_____ Date of Birth: _____

Height:_____ Weight:_____ % of Body Fat (optional):_____ Pulse:_____ BP ___/___(___/___, ___/___)

Vision: R 20/_____ L 20/_____ Corrected: Y N Pupils: Equal _____ Unequal _____

	Normal	Abnormal Findings	Initials*
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

* Station based examination only

CLEARANCE

_____ Cleared and have reviewed questionnaire on reverse side

_____ Cleared after completing evaluation/rehabilitation for: _____

_____ Not cleared for:_____ Reason:_____

Recommendations: _____

PHYSICIAN'S ADDRESS AND SIGNATURE

Name of Physician, NP,PA (print or type): _____

Address:_____

Phone:_____ Date: _____

Signature of Physician:

MD, DO, Nurse Practitioner, Physician Assistant

Stamp with Name of Doctor or Medical Office/Clinic (Required to be accepted)