PLEASE RETURN TO MAIN OFFICE UPON COMPLETION

Pre-Participation Physical

Name: ___________________________________ Age: ______ Date of Birth: ____________ Grade: ______

Address: _________________________________ City: ___________________________ Zip: ___________

Parent/Guardian home phone _________________ Father work #______________ Mother work #___________

Doctor's Name ____ Phone # __________________________

Doctor's Address ____

Sport(s): ____ Student ID# __________________
(Please list all sports participating in for all seasons)

HEALTH HISTORY (MUST BE COMPLETED PRIOR TO THE EXAMINATION)

YES OR NO – HAS THE STUDENT HAD ANY:

1. ____ ____ Chronic or recurrent illness?
2. ____ ____ Illness lasting over 1 week?
3. ____ ____ Hospitalization?
4. ____ ____ Missing organs?
6. ____ ____ Allergies (medications, food)?
7. ____ ____ Problems with heart/blood pressure?
8. ____ ____ Chest pain/severe shortness of breath W/exercise?
9. ____ ____ Dizziness or fainting with exercise?
10. ____ ___Fainting, bad headaches or convulsions?
11. ____ ____ Concussion or loss of consciousness?
12. ____ ____ Heat exhaustion, heatstroke, or other problems with heat?

YES OR NO – IS THERE ANY HISTORY OF:

13. ____ ____ Injuries requiring physical treatment?
14. ____ ____ Neck or back injury?
15. ____ ____ Knee injury?
17. ____ ____ Ankle injury?
18. ____ ____ Other serious joint injury?
19. ____ ____ Broken bones (fractures)?

YES OR NO – FURTHER HISTORY:

20. ____ ____ Is there any reason why this student should not participate in sports?
21. ____ ____ Has any family member died suddenly at less than 40 years of age? Of causes other than an accident?
22. ____ ____ Has any family member had a heart attack at less than 55 years of age? Of what age?

YES OR NO – DOES THIS STUDENT:

23. ____ ____ Wear eyeglasses or contact lenses?
24. ____ ____ Wear dental bridges, braces, retainers or plates?
25. ____ ____ Take any medications? Please list. ____

Date of last known tetanus shot: ____

Use this space to explain any yes answers to the above questions:

____
____
____
____
____
____
____
____

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Athletic Medical Exam Screening

General Examination to be completed by the examining physician

Sport (s) ____

	Normal	Abnormal (describe)
Eyes, Ears, Nose, Throat:		
Skin:		
Lungs:		
Heart:		
Abdomen:		

Pulse ____________________
Blood Pressure _____________
Height ____________________
Weight ____________________
Visual Acuity R: ___________
L: ___________

Suggested Musculoskeletal Exam

Neck

Motion/Strength		
Flexion	___	___
Extension	___	___
Rotation	___	___
Lateral Flexion Right	___	___
Lateral Flexion Left	___	___

Shoulder

MOTION/STRENGTH		
Forward Flexion	___	___
Abduction	___	___
Extension	___	___
Internal Rotation	___	___
External Rotation	___	___
Horizontal Adduction	___	___
STABILITY	___	___
A/C JOINT	___	___

Elbow

MOTIONS/STRENGTH		
Biceps Flexion	___	___
Triceps Extension	___	___
Supination	___	___
Pronation	___	___

	NL	AB	Describe Abnormal
Knee Joint			
Effusion	____	____	______________________
Tenderness	____	____	______________________
Quadriceps			
Size	____	____	______________________
Defects	____	____	______________________
Patella			
Tenderness	____	____	______________________
Crepitus	____	____	______________________
Abnormal Tracking	____	____	______________________
Subluxable	____	____	______________________
Patellar Tendon	____	____	______________________
Tibial Tubercle	____	____	______________________
Ligaments	____	____	______________________
Medical Collateral	____	____	______________________
Lateral Collateral	____	____	______________________
Anterior Cruciate	____	____	______________________
Posterior Cruciate	____	____	______________________
Cartilage Testing	____	____	______________________
Strength	____	____	______________________
Hip Flexors	____	____	______________________
Hamstrings	____	____	______________________

General Flexibility

Hamstrings	___	___
Lumbar Spine	___	___
Adductors	___	___
Achilles	___	___
Wrist/Hand	___	___

Ankle

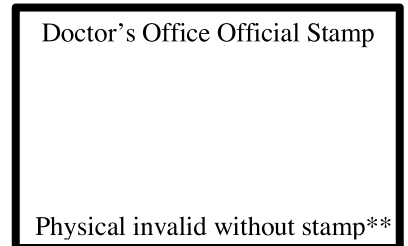
Motion/Strength		
Plantar Flexion	____	____
Dorsiflexion	____	____
Inversion	____	____
Eversion	____	____
Spine/Scoliosis	____	____

Recommendations:

__________ **UNLIMITED PARTICIPATION**
__________ Clearance withheld pending further evaluation (comment below)
__________ Participation limited to specific athletic components (comment below)
__________ NO athletic participation (comment below)

Comments:

____



Signature____ MD/DO Date_____________________