



Pre-Participation Physical Evaluation

(This page to be completed by physician/nurse practitioner/physician assistant)

PHYSICAL EXAMINATION

NAME _____ DATE OF EXAM _____
DATE OF BIRTH _____
HEIGHT _____ WEIGHT _____ % BODY FAT (optional) _____ PULSE _____ BP _____
VISION R 20/ _____ L 20/ _____ CORRECTED? Y _____ N _____ PUPILS: EQUAL _____ UNEQUAL _____

	NORMAL	ABNORMAL FINDING	INITIALS *
<u>MEDICAL</u>			
Appearance _____			
Eyes/Ears/Nose/Throat _____			
Lymph nodes _____			
Heart _____			
Pulses _____			
Lungs _____			
Abdomen _____			
Genitalia (males only) _____			
Skin _____			
<u>MUSCULOSKELETAL</u>			
Neck _____			
Back _____			
Shoulder/Arm _____			
Elbow/Forearm _____			
Wrist/Hand _____			
Hip/Thigh _____			
Knee _____			
Leg/Ankle _____			
Foot _____			

*Station-based examination only

CLEARANCE

☐ Cleared

☐ Cleared after completing evaluation/rehabilitation for: _____

☐ Not cleared for [Sport(s)]: _____ Reason: _____

Recommendation: _____

Name of physician/nurse practitioner/physician assistant _____ Date: _____
(PRINT OR TYPE)

Address: _____ Phone: _____

Signature of physician/nurse practitioner/physician assistant _____

PHYSICIANS STAMP:

Endorsed by the MPSSAA

Pre-Participation Physical Evaluation



HISTORY

This page to be completed by student and parent/guardian

Name _____	Sex _____	Age _____	Date of Birth _____
Grade _____	School _____	Sport(s) _____	
Address _____			
Personal physician _____			
In case of emergency, contact			
Name _____	Relationship _____	Phone (H) _____	(W) _____

Explain "Yes" answers below. Circle questions if you don't know the answers.

	YES	NO		YES	NO	
1. Have you had a medical illness or injury since your last check up or sports physical?	☐	☐	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 aid)?	☐	☐	
Do you have an ongoing or chronic illness?	☐	☐	11. Have you had any problems with your eyes or vision?	☐	☐	
2. Have you ever been hospitalized overnight?	☐	☐	Do you wear glasses, contacts, or protective eyewear?	☐	☐	
Have you ever had surgery?	☐	☐	12. Have you ever had a sprain, strain, or swelling after injury?	☐	☐	
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?	☐	☐	Have you broken or fractured any bone, or dislocated any joints?	☐	☐	
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	☐	☐	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	☐	☐	
4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	☐	☐	<i>If yes, check appropriate box and explain below.</i>			
Have you ever had a rash or hives develop during or after exercise?	☐	☐	☐ Head	☐ Upper arm	☐ Hand	☐ Knee
5. Have you ever passed out during or after exercise?	☐	☐	☐ Back	☐ Elbow	☐ Finger	☐ Shin/calf
Have you ever been dizzy during or after exercise?	☐	☐	☐ Chest	☐ Forearm	☐ Hip	☐ Ankle
Have you ever had chest pain during or after exercise?	☐	☐	☐ Shoulder	☐ Wrist	☐ Thigh	☐ Foot
Do you get tired more quickly than your friends do during exercise?	☐	☐	13. Do you want to weigh more or less than you do now?	☐	☐	
Have you ever had racing of your heart or skipped heartbeats?	☐	☐	Do you lose weight regularly to meet weight requirements for your sport?	☐	☐	
Have you had high blood pressure or high cholesterol?	☐	☐	14. Do you feel stressed out?	☐	☐	
Have you ever been told you have a heart murmur?	☐	☐	15. Record the dates of your most recent immunizations (shots) for:			
Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐	Tetanus _____	Measles _____		
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	☐	☐	Hepatitis B _____	Chickenpox _____		
Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐				
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	☐	☐				
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?	☐	☐				
Have you ever had a stinger, burner, or pinched nerve?	☐	☐				
8. Have you ever become ill from exercising in the heat?	☐	☐				
9. Do you cough, wheeze, or have trouble breathing during or after activity?	☐	☐				
Do you have asthma?	☐	☐				
Do you have seasonal allergies that require medical treatment?	☐	☐				

FEMALES ONLY

16. When was your first menstrual period? _____

When was your most recent menstrual period? _____

How much time do you usually have from the start of one period to the start of another? _____

How many periods have you had in the last year? _____

What was the longest time between periods in the last year? _____

Explain "Yes" answers here: _____

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

Signature of athlete _____ Signature of parent/guardian _____ Date _____