

PHYSICAL EXAMINATION

(To be completed by physician)

Name _____		Date of birth _____	
Height _____	Weight _____	Pulse _____	BP _____ / _____
			BP Reference Range 10-12 yo > 125/80
			13-15 yo > 135/85
			16-18 yo > 140/90
Vision R 20/____ L 20/____ Corrected: Y N			

	NORMAL	ABNORMAL FINDINGS	INITIALS
MEDICAL			
Appearance			
Eyes/Ears/Nose/throat			
Lymph Nodes			
Heart			
Pulses			
Lungs Abdomen			
Skin			
Genitalia (males only)			

MUSCULOSKELETAL

Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hips/thigh			
Knee			
Leg/ankle			
Foot			

Season based examination only

CLEARANCE

- Cleared
- Cleared after completing evaluation/rehabilitation for: _____

- Not cleared for: _____ Reason: _____

Recommendations: _____

Name of physician (print/type) _____ Date _____

Signature of physician _____, MD or DO

AUGUSTA PREPARATORY DAY SCHOOL
PRE-PARTICIPATION PHYSICAL EVALUATION

Grade _____
 School Year 20 ____ - ____

HISTORY

(To be completed by athlete and parent/guardian prior to examination)

Date of Exam _____

NAME _____ SEX _____ AGE _____ DOB _____

ADDRESS _____

PHONE _____ PERSONAL PHYSICIAN _____

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

- | | Yes | No | | 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? | ___ | ___ | 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 esthetics, retainer on your teeth, hearing aid)? | ___ | ___ |
| 2. Have you ever been hospitalized overnight?
Have you ever had surgery? | ___ | ___ | 11. Have you had any problems with your eyes or vision?
Do you wear glasses, contacts, or protective eyewear? | ___ | ___ |
| 3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler? | ___ | ___ | 12. Have you broken or fractured any bones or injured any joints?

Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?
If yes, check appropriate line and explain below. | ___ | ___ |
| 4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? | ___ | ___ | ___ Head ___ Elbow ___ Hip | | |
| 5. Have you ever passed out during or after exercise?
Have you ever been dizzy during or after exercise?
Have you ever had chest pain during or after exercise?
Have you ever had racing of your heart or skipped heartbeats?
Have you ever been told you have a hear murmur?
Has any family member died of heart problems or of sudden death before age 50?
Has a physician ever denied or restricted your participation in sports for any heart problems? | ___ | ___ | ___ Neck ___ Forearm ___ Thigh | | |
| 6. Do you have any current skin problems (for example itching, rashes, acne, warts, fungus, or blisters)? | ___ | ___ | ___ Back ___ Wrist ___ Knee | | |
| 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? | ___ | ___ | ___ Chest ___ Hand ___ Shin/calf | | |
| 8. Have you ever become ill from exercising in the heat? | ___ | ___ | ___ Shoulder ___ Finger ___ Ankle | | |
| 9. Do you cough, wheeze, or have trouble breathing during or after activity?
Do you have asthma? | ___ | ___ | ___ Upper arm | | |
| | | | FEMALES ONLY | | |
| | | | 16. Are you having regular menstrual periods? | ___ | ___ |
| | | | Explain "Yes" answers here: _____ | | |
| | | | _____ | | |
| | | | _____ | | |
| | | | _____ | | |
| | | | _____ | | |

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

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