Archdiocese of Miami
Office of Catholic Schools

Athletic Pre-participation Physical Evaluation (Page 1 of 2)

This completed form must be kept on file by the school

Part 1. Student Information (to be completed by the parent).

Student Name:_____ Sex:_____ Age_____ Date of Birth_____/_____/_____

School:_____ Grade in School_____ Sport(s) expected to play_____

Home Address:_____ Home Phone ( )_____

Name of Parent/Guardian:_____

Person to Contact in Case of Emergency:_____

Relationship to Student:_____Home Phone: ( )_____ Work Phone: ( )_____

Personal/Family Physician:_____ City/State:_____ Office Phone: ( )_____

Part 2. Medical History (to be completed by parent). Explain "yes" answers below. Circle questions for which you do not know the answer

	Yes	No
1. Has child had a medical illness or injury since the last check up or sports physical?	____	____
2. Does child have an ongoing chronic illness?	____	____
3. Has child ever been hospitalized overnight?	____	____
4. Has child ever had surgery?	____	____
5. Is child currently taking any prescription or nonprescription (over the counter) medications or pill or using an inhaler?	____	____
6. Has child ever taken any supplements or vitamins to help gain or lose weight or improve performance?	____	____
7. Does child have any allergies (for example to pollen, medicine, food or stinging insects)?	____	____
8. Has child ever had rash or hives develop during or after exercise?	____	____
9. Has child ever passed out during or after exercise?	____	____
10. Has child ever been dizzy during or after exercise?	____	____
11. Has child ever had chest pain during or after exercise?	____	____
12. Does child get tired more quickly than friends during exercise?	____	____
13. Has child ever had racing of the heart of skipped heartbeats?	____	____
14. Has child had high blood pressure or high cholesterol?	____	____
15. Has child ever been told he/she has a heart murmur?	____	____
16. Has any family member or relative died of heart problems or sudden death before age 50?	____	____
17. Has child had severe viral infection (for example, myocarditis or mononucleosis) within the last month?	____	____
18. Has a physician ever denied or restricted child's participation in sports for any heart problems?	____	____
19. Does child have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	____	____
20. Has child ever had a head injury or concussion?	____	____
21. Has child ever been knocked out, become unconscious, or lost his/her memory?	____	____
22. Has child ever had a seizure?	____	____
23. Does child have frequent or severe headaches?	____	____
24. Has child ever had numbness or tingling in his/her arms, hands, legs, or feet?	____	____
25. Has child ever had a stinger, burner, or pinched nerve?	____	____

	Yes	No
26. Has child ever become ill from exercising in the heat?	____	____
27. Does child cough, wheeze or have trouble breathing during or after activity?	____	____
28. Does child have asthma?	____	____
29. Does child have seasonal allergies that require medical treatment?	____	____
30. Does child have 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)?	____	____
31. Has child had any problems with his/her eyes or vision?	____	____
32. Does child wear glasses, contacts, or protective eye wear?	____	____
33. Has child ever had a sprain, strain, or swelling after injury?	____	____
34. Has child broken or fractured any bones or dislocated any joints?	____	____
35. Has child had any other problems with pain or swelling in muscles, tendons, bones, or joints?	____	____

If yes, check appropriate blank and explain below:

___ *Head*	___ *Elbow*	___ Hip
___ Neck	___ Forearm	___Thigh
___ Back	___ Wrist	___Knee
___ Chest	___ Hand	___Shin/Calf
___ Shoulder	___ Finger	___ Ankle
___ Upper Arm	___ Foot	

36. Does child want to weigh more or less than child weighs now?	____	____
37. Does child lose weight regularly to meet weight requirements for a sport?	____	____
38. Does child feel stressed out?	____	____

39. Record the dates of his/most recent immunizations (shots) for:

Tetanus_____ Measles:_____

Hepatitus B_____ Chickenpox:_____

Explain "Yes" answers here: _____

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

Signature of Parent/Guardian_____ Date:_____

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Part 3. Physical Examination (to be completed by physician).

Student Name:_____ Date of Birth_____/_____/_____

Height: _____ Weight: _____ % Body Fat (optional):_____ Pulse:_____ Blood Pressure: _____/_____ (_____/_____ , _____/_____)

Visual Acuity: Right 20/_____ Left 20/_____ Corrected: Yes No Pupils: Equal_____ Unequal _____

FINDINGS	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
1. Appearance	_____	_____	_____
2. Eyes/Ears/Nose/Throat	_____	_____	_____
3. Lymph Nodes	_____	_____	_____
4. Heart	_____	_____	_____
5. Pulses	_____	_____	_____
6. Lungs	_____	_____	_____
7. Abdomen	_____	_____	_____
8. Skin	_____	_____	_____
MUSCULOSKELETAL			
9. Neck	_____	_____	_____
10. Back	_____	_____	_____
11. Shoulder/Arm	_____	_____	_____
12. Elbow/Forearm	_____	_____	_____
13. Wrist/Hand	_____	_____	_____
14. Hip/Thigh	_____	_____	_____
15. Knee	_____	_____	_____
16. Leg/Ankle	_____	_____	_____
17. Foot	_____	_____	_____

* - Station-based examination only

ASSESSMENT OF EXAMINING PHYSICIAN

_____Cleared without limitation

_____Not cleared for_____ Reason_____

_____Cleared after completing evaluation/rehabilitation for:_____

_____Referred to_____ For_____

_____

Recommendations:_____

_____

Name of Physician (print or type):_____ Date:_____

Address:_____

Signature of Physician:_____, MD, DO, DC, ARNP

ASSESSMENT OF PHYSICIAN TO WHOM REFERRED (if applicable)

I hereby certify that the examination(s) for which referred was/were performed by myself or an individual under my direct supervision with the following conclusion(s)

_____Cleared without limitation

_____Not cleared for_____ Reason_____

_____Cleared after completing evaluation/rehabilitation for:_____

_____Referred to_____ For_____

_____

Recommendations:_____

_____

Name of Physician (print or type):_____ Date:_____

Address:_____

Signature of Physician:_____, MD, DO, DC, ARNP

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 for Sports Medicine.