Student's Name: ____ Date of Birth:_____________________

Sex: ______ Age:_____ School: __________ Grade: ______ Sport(s): ____

Home Address:____ Phone: ________________________

Parent's Email: ____

Medicines & Allergies: Please list all of the prescription and over-the-counter medicines and supplements that you are currently taking:
____
____
Do You have any allergies? ___ Yes ____ No If yes, please identify and specify below:
___ Medicines ___Pollens ___ Food ___Stinging Insects ___ Other
Specify Here:____

General Questions	Yes	No
1a. Has a doctor ever denied or restricted your participation in sports for any reason?		
1b. Have you had a medical illness or injury since your last sports physical?		
2.. Do you have any ongoing medical conditions? If yes, please identify below: Asthma Anemia Diabetes Infections Other:		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
Heart Health Questions	Yes	No
5. Have you ever passed out or nearly passed out during or after exercise?		
6. Have you ever had pain, tightness or pressure in you chest during exercise?		
7. Does your heart ever race or skip beats during exercise?		
8. Has a doctor ever told you that you have any heart problems? If yes, please identify below: High blood pressure Heart murmur High cholesterol Heart infection Kawasaki disease Other:		
9. Has a doctor ever ordered a test for your heart?(ECG/EKG, echo, ect)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexpected seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
Family Heart Health Questions	Yes	No
13. Have any of your relatives/family members died of heart problems or had any unexplained/unexpected death before age 50? (including drowning, unexplained car accident, or sudden infant death syndrome)		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmic right ventricular cariomyopathy, long/short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker or other device?		
16. Has anyone in your family had unexplained seizures or near drowning?		
Bone and Joint Questions	Yes	No
17. Have you ever had a bone, muscle, ligament or tendon injury that caused you to miss practice/games?		
18. Have you ever broken/fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injection, therapy, a brace/cast or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have had an xray for neck instability or atlantoaxial instability? (down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do any of your joints become painful, swollen, feel warm or look red?		
24. Do you have a history of juvenile arthritis or connective tissue disease?		

25. Do you have a bone, muscle or joint injury that bothers you? If yes, please identify below: Head Neck Back Chest Shoulder Upper Arm Elbow Forearm Wrist Hand Hip Thigh Knee Shin/Calf Ankle Foot		
Medical Questions	Yes	No
26. Do you cough, wheeze or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, eye, testicle (males), your spleen or other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis within the last month?		
32. Do you have any rashes, pressure sores or other skin problems?		
33. Have you ever had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you get headaches with exercise?		
38. Have you ever had numbness, tingling or weakness in your arms of legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps while exercising?		
42. Do you or someone in you family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contacts?		
46. Do you wear protective eyewear such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
Females Only	Yes	No
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period? Age _______		
54. How many periods have you had in the last 12 months? # _______		

Explain YES answers:

Preparticipation Physical Evaluation PHYSICAL EXAMINATION FORM

Name ____ Date of birth _____________________

EXAMINATION			
Height Weight · Male · Female Stress BP: (____/____) ; (____/____)			
BP Pulse Vision R: L: B: Corrected · Yes · No			
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**	N
Appearance Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)			
Eyes/ears/nose/throat Pupils equal Hearing			
Lymph nodes			
Heart a Murmurs (auscultation standing, supine, +/- Valsalva) Location of point of maximal impulse (PMI)			
Pulses Simultaneous femoral and radial pulses			
Lungs			
Abdomen			
Genitourinary (males only)b			
Skin HSV, lesions suggestive of MRSA, tinea corporis			
Neurological			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			
Functional: Duck-walk, single leg hop			

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

- Cleared for all sports without restriction
- Cleared for all sports without restriction with recommendations for further evaluation or treatment for ____

____

- Not cleared
- Pending further evaluation
- For any sports
- For certain sports ____

Reason ____

Recommendations ____

____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _Dr. Brent G. Hextell #16-33074370____ Date ______________

Address ________1230 W. Ash Street Suite #1, Windsor, CO 80550____ Phone _970-674-0147________________

Signature of physician ____,

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