Archdiocese of Miami
Department of 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?		
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

	Yes	No
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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Athletic Pre-participation Physical Evaluation (Page 2 of 2)

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Part 3. Physical Exam ination (to be com pleted by physician).

Student Nam e:_____ Date of Birth_____/_____/_____ Height: _____ W

eight: _____ % Body Fat (optional):_____ Pulse:_____ Blood Pressure: _____/_____ (_____/_____ , _____/_____) Visual Acuity: Right 20/_____ Left 20/_____

Corrected: Yes No Pupils: Equal_____ Unequal _____

FINDINGS NORM AL ABNORM AL FINDINGS INITIALS* MEDICAL

1. Appearance _____ _____ _____ 2. Eyes/Ears/Nose/Throat _____

_____ _____ 3. Lym ph Nodes _____

_____ _____ 4. Heart _____

_____ _____ 5. Pulses _____

_____ _____ 6. Lungs _____

_____ _____ 7. Abdom en _____

_____ _____ 8. Skin _____

_____ _____ MUSCULOSKELETAL

9. Neck _____ _____ _____ 10. Back _____

_____ _____ 11. Shoulder/Arm _____

_____ _____ 12. Elbow/Forearm _____

_____ _____ 13. W rist/Hand _____

_____ _____ 14. Hip/Thigh _____

_____ _____ 15. Knee _____

_____ _____ 16. Leg/Ankle _____

_____ _____ 17. Foot _____

_____ _____ * - Station-based exam ination only

ASSESSMENT OF EXAMINING PHYSICIAN

_____Cleared without lim itation

_____Not cleared for_____ Reason_____ _____Cleared after com

pleting evaluation/rehabilitation for:_____ _____Referred

to_____ For_____

_____ Recom m

endations:_____

_____ Nam e of Physician (print

or type):_____ Date:_____

Address:_____ Signature of

Physician:_____, MD, DO, DC, ARNP *ASSESSMENT OF PHYSICIAN TO W HOM 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 lim itation

_____Not cleared for_____ Reason_____ _____Cleared after com

pleting evaluation/rehabilitation for:_____ _____Referred

to_____ For_____

_____ Recom m

endations:_____

_____ Nam e 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.