ATTENTION PARENT/GUARDIAN: The preparticiaption physical examination (page 3) must be completed by a health care provider who has completed the Student-Athlete Cardiac Assessment Professional Development Module.

#### ■ PREPARTICIPATION PHYSICAL EVALUATION

#### HISTORY FORM

(Note: This form is to be filled out E	y the patient and parent	prior to	seein	g the physician. The physician should keepa copy of this form in the	e chart.	)		
				Date of birth				
				Sport(s)				
				nedicines and supplements (herbal and nutritional) that you are currently				
Do you have any allergies? ☐ Yes☐ Medicines	□ No If yes, please iden □ Pollens	tify spe	ecific al	lergy below.  □ Food □ Stinging Insects				
Explain "Yes" answers below. Circle question	ons you don't know the ans	wers to	0.					
GENERAL QUESTIONS	-	Yes	No	MEDICAL QUESTIONS	Yes	No		
Has a doctor ever denied or restricted your pany reason?	participation in sports for			26. Do you cough, wheeze, or have difficulty breathing during or after exercise?				
Do you have any ongoing medical conditions below: ☐ Asthma ☐ Anemia ☐ Dia				27. Have you ever used an inhaler or taken asthma medicine?  28. Is there anyone in your family who has asthma?				
Other:  3. Have you ever spent the night in the hospita				29. Were you born without or are you missing a kidney, an eye, a testicle				
Have you ever spent the night in the nospital     Have you ever had surgery?	1?			(males), your spleen, or any other organ?  30. Do you have groin pain or a painful bulge or hernia in the groin area?				
HEART HEALTH QUESTIONS ABOUT YOU		Yes	No	31. Have you had infectious mononucleosis (mono) within the last month?				
Have you ever passed out or nearly passed of AFTER exercise?	out DURING or			32. Do you have any rashes, pressure sores, or other skin problems?				
Have you ever had discomfort, pain, tightness	s or pressure in your			33. Have you had a herpes or MRSA skin infection?				
chest during exercise?	se, or procedure in your			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,				
7. Does your heart ever race or skip beats (irre	gular beats) during exercise?			prolonged headache, or memory problems?				
8. Has a doctor ever told you that you have any check all that apply:	heart problems? If so,			36. Do you have a history of seizure disorder?				
☐ High blood pressure ☐ A heart	murmur			37. Do you have headaches with exercise?				
☐ High cholesterol ☐ A heart ☐ Kawasaki disease Other:	infection			38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?				
Has a doctor ever ordered a test for your heal echocardiogram)	art? (For example, ECG/EKG,			39. Have you ever been unable to move your arms or legs after being hit or falling?				
10. Do you get lightheaded or feel more short of during exercise?	breath than expected			40. Have you ever become ill while exercising in the heat?  41. Do you get frequent muscle cramps when exercising?				
11. Have you ever had an unexplained seizure?				42. Do you or someone in your family have sickle cell trait or disease?				
12. Do you get more tired or short of breath more	re quickly than your friends			43. Have you had any problems with your eyes or vision?				
during exercise?  HEART HEALTH QUESTIONS ABOUT YOUR FAI	MIIV	Yes	No	44. Have you had any eye injuries?				
13. Has any family member or relative died of h		163	NO	45. Do you wear glasses or contact lenses?		_		
unexpected or unexplained sudden death be drowning, unexplained car accident, or sudd	fore age 50 (including			46. Do you wear protective eyewear, such as goggles or a face shield?  47. Do you worry about your weight?				
14. Does anyone in your family have hypertroph	ic cardiomyopathy, Marfan			48. Are you trying to or has anyone recommended that you gain or				
syndrome, arrhythmogenic right ventricular syndrome, short QT syndrome, Brugada syn				lose weight?				
polymorphic ventricular tachycardia?	aromo, or oatoonolaminorgio			49. Are you on a special diet or do you avoid certain types of foods?  50. Have you ever had an eating disorder?				
15. Does anyone in your family have a heart pro	blem, pacemaker, or			51. Do you have any concerns that you would like to discuss with a doctor?				
implanted defibrillator?  16. Has anyone in your family had unexplained f	fainting unexplained			FEMALES ONLY				
seizures, or near drowning?	5,			52. Have you ever had a menstrual period?				
BONE AND JOINT QUESTIONS		Yes	No	53. How old were you when you had your first menstrual period?				
<ol> <li>Have you ever had an injury to a bone, musc that caused you to miss a practice or a gam</li> </ol>				54. How many periods have you had in the last 12 months?				
18. Have you ever had any broken or fractured by	oones or dislocated joints?			Explain "yes" answers here				
19. Have you ever had an injury that required x-injections, therapy, a brace, a cast, or crutch								
20. Have you ever had a stress fracture?				]				
21. Have you ever been told that you have or ha instability or atlantoaxial instability? (Down s								
22. Do you regularly use a brace, orthotics, or of	ther assistive device?			]				
23. Do you have a bone, muscle, or joint injury t	-							
24. Do any of your joints become painful, swolle								
25. Do you have any history of juvenile arthritis	or connective tissue disease?			] ————				
I hereby state that, to the best of my kno	owledge, my answers to t	he abo	ve que	stions are complete and correct.				
Signature of athlete	Signature of	parent/gi	uardian _	Date				
© 2010 American Academy of Family Dharistan	American Academy of Parli-4-1	no 1	ioon Cal	laga of Charta Madiaina American Madiaal Conicty for Charta Madiaina American	Outhon	dia		

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### ■ PREPARTICIPATION PHYSICAL EVALUATION

# THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam											
Name				Date of birth							
	A	Orede	Cohool								
Sex	_ Age	Grade	School	Sport(s)							
1. Type of dis	sability										
2. Date of dis											
3. Classificat	tion (if available)										
4. Cause of c	disability (birth, disea	ase, accident/trauma, other)									
5. List the sp	orts you are interes	sted in playing									
					Yes	No					
6. Do you req	6. Do you regularly use a brace, assistive device, or prosthetic?										
7. Do you use any special brace or assistive device for sports?											
8. Do you ha	8. Do you have any rashes, pressure sores, or any other skin problems?										
	9. Do you have a hearing loss? Do you use a hearing aid?										
	10. Do you have a visual impairment?										
		es for bowel or bladder functi	on?								
		mfort when urinating?									
	had autonomic dysr										
_			hermia) or cold-related (hypothermia) illnes	8?							
	ve muscle spasticity	y? s that cannot be controlled by	, madination?								
		s mai cannot be controlled by	/ medication?								
Explain "yes" a	answers here										
Please indicate	e if you have ever l	had any of the following.									
					Yes	No					
Atlantoaxial in											
	on for atlantoaxial in	nstability									
					Dislocated joints (more than one)						
		Easy bleeding Easy bleeding									
	en	Enlarged spieen Enlarged spieen									
	Hepatitis Color of the color of										
Osteopenia or osteoporosis											
Difficulty contr	rolling bowel										
Difficulty contr	rolling bowel rolling bladder	vande.									
Difficulty contr Difficulty contr Numbness or t	rolling bowel rolling bladder tingling in arms or h										
Difficulty contr Difficulty contr Numbness or t	rolling bowel rolling bladder tingling in arms or h tingling in legs or fe										
Difficulty contr Difficulty contr Numbness or t Numbness or t Weakness in a	rolling bowel rolling bladder tingling in arms or h tingling in legs or fe arms or hands										
Difficulty contr Difficulty contr Numbness or 1 Numbness or 1 Weakness in a	rolling bowel rolling bladder tingling in arms or h tingling in legs or fe- urms or hands egs or feet										
Difficulty contr Difficulty contr Numbness or 1 Numbness or 1 Weakness in a Weakness in le	rolling bowel rolling bladder tingling in arms or h tingling in legs or fe arms or hands egs or feet e in coordination										
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Difficulty controlled by the c	rolling bowel rolling bladder tingling in arms or h tingling in legs or fe trms or hands egs or feet e in coordination e in ability to walk answers here	et	rs to the above questions are complete a	and correct.							
Difficulty controlled by the c	rolling bowel rolling bladder tingling in arms or h tingling in legs or fe trms or hands egs or feet e in coordination e in ability to walk answers here	et	rs to the above questions are complete a  Signature of parent/guardian	and correct.	Date						

**NOTE:** The preparticiaption physical examination must be conducted by a health care provider who 1) is a licensed physician, advanced practician nurse, or physician assistant; and 2) completed the Student-Athlete Cardiac Assessment Professional Development Module.

\_\_ Date of birth \_\_

#### ■ PREPARTICIPATION PHYSICAL EVALUATION

## PHYSICAL EXAMINATION FORM

Name

1. Consider additional questions on more sensitive issues	PHYSICIA	AN REMINDE	RS						(1	Date of Exam
Meging   Weight   Disks   Disks   207   L 207   Corrected   Disks   Disks   207   L 207   Corrected   Disks	Do you Do you Have y During Do you Have y Have y Have y Do you	u feel stressed o u ever feel sad, u feel safe at yo you ever tried ci o u drink alcohol o you ever taken a you ever taken a u wear a seat be u wear a seat be	out or und hopeless, ur home o garettes, ys, did yo or use any unabolic s iny supplett, use a	der a lo , depre or resion chewing use y other steroid ement helme	ot of presessed, or dence? ng tobac chewing r drugs? s or use s to help t, and us	ssure? anxious? cco, snuff, or dip; tobacco, snuff, d any other perfc you gain or lose e condoms?	or dip? ormance supplement? oweight or improve your	performance?		
BEDICAL  Appearance  MINTER  M	EXAMINAT	rion								
MORMAL   ABNORMAL PHONICS	Height			1	Weight		☐ Male	☐ Female		
Appearance	BP	/	(	/	)	Pulse	Vision	R 20/	L 20/	Corrected □ Y □ N
Moran signman below hospitals, high-arched polates, pecture excevature, annihondachyly, amin span hospital, hyperizody, reyopia, JAPP, aodit insufficiency) Epecies shocethroat Pepals equal Pepals equ	MEDICAL							NORMAL		ABNORMAL FINDINGS
am son > height, hypertexty, myopis, MVP, aortic insufficiency)  Fige-insurfaces Method  Public equal  Heisting  Lymph nodes  Heisting										
Pulse requal Hearing Lymph nodes Hearing Lymph nodes Hearing	arm spa	ın > height, hype					tum, arachnodactyly,			
Hearing										
Lymph nodes										
Murray (susculation standing, supine, +/ Vasibale)     Location of point of maximal impulse (PMI)     Pulses     Simultaneous femoral and radial pulses     Lungs     Adodomen     Genitouristay (males only)*     Moderna										
Location of point of maximal impulse (PMI) Paleses     Simultaneous femoral and radial pulses     Lungs     Addomen     Centitourinary (males only)* Solin     Hot, lesions suggestive of MRSA, linea corporis     Nect Centitourinary (males only)* Solin     Host Centification of the Centification of										
Simultaneous femoral and radial pulses Lungs Abdomon Cernitorninary (males only)* Son * 150, Issions suggestive of MRSA, tinea corporis * 150, Is						lva)				
Lungs Abdomen  Abdomen  Borthourinary (males only)*  Skin  BSV, lesions suggestive of MRSA, tinea corporis  Neurologic*  Neurologic*  Neurologic*  Neurologic*  Neurologic*  Neck  Back  Shoulder/arm  EDover/orearm  Hiphtligh  Knee  Lag/ankle  Foot/forearm  Lag/ankle  Foot/forearm  Lag/ankle  Foot/forearm  Cardiot of users in juny interesting the properties of the propert										
Address		neous femoral an	a radial p	ulses						
Centionizary (males only)*   Skin										
Side  **HSV, lesions suggestive of MRSA, linea corporis  Neurologic*  **MUSCULOSKEETAL  **MUSCULOSKEETAL  **Back  **Back  **Back  **Back  **Boulderarm  **Elbow/brearm  **Wisshand/fingers  **Hightingh  **Knee  **Legankle  **Fourthoral  **Pounting and the selection of the selecti		ary (males only)b								
In Its leasons suggestive of MRSA, finea corports      Musculogics:      Muscul		iry (males omy)								
Neck Neck Neck Noulde/arm Nour Elbow/forearm Nrist/hand/fingers Highrligh Knee Leg/ankle Foot/fores Functional **Duck-walk, single leg hop **Consider EOk, encludingorm, and referral to cardiology for abnormal cardiac history or exam. **Consider EOk, encludingorm, and referral to cardiology for abnormal cardiac history or exam. **Consider EOK, encludingorm, and referral to cardiology for abnormal cardiac history or exam. **Consider EOK, encludingorm, and referral to cardiology for abnormal cardiac history or exam. **Consider EOK, encludingorm, and referral to cardiology for abnormal cardiac history or exam. **Consider EOK, encludingorm, and referral to cardiology for abnormal cardiac history or exam. **Consider EOK, encludingorm, and referral to cardiology for abnormal cardiac history or exam. **Consider EOK, encludingorm, and referral to cardiology for abnormal cardiac history or exam. **Consider EOK, encludingorm, and referral to cardiology for abnormal cardiac history or exam. **Consider EOK, encludingorm, and referral to cardiology for abnormal cardiac history or exam. **Consider EOK, encludingorm, and referral to cardiology for abnormal cardiac history or exam. **Consider EOK, encluding thir private setting, Having Bird party present is recommended. **Consider EOK, encluding Bird private requirements of the setting Having Bird participation with recommendation or treatment for		ions suggestive of	of MRSA, t	tinea co	orporis					
Neck Back Back Back Back Back Back Back Ba	Neurologic	С								
Back Shoulderfarm	MUSCULO	SKELETAL								
Shoulder/arm	Neck									
Elbow/forearm Wrist/hand/fingers Hip/thigh Knee Leg/ankle Foot/lose Functional **Duck-walk, single leg hop **Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam. **Consider CEG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam. **Consider CEG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam. **Consider Cell exam if in private setting, Having third party present is recommended. **Consider Cell exam if in private setting, Having third party present is recommended. **Consider Cell exam if in private setting, Having third party present is recommended. **Consider Cell exam if in private setting, Having third party present is recommended. **Consider Cell exam if in private setting, Having third party present is recommended. **Consider Cell exam if in private setting, Having third party present is recommended. **Consider Cell exam if in private setting, Having third party present is recommended to recommended for Pending further evaluation or treatment for    Not cleared   Pending further evaluation   Pen										
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AddressPhone Signature of physician, APN, PA	participate i arise after tl	in the sport(s) a he athlete has b	s outline een clear	d abov red for	e. A cop	y of the physical	exam is on record in my	office and can be m	iade available to tl	he school at the request of the parents. If conditions
Signature of physician, APN, PA	Name of ph	nysician, advano	ed pract	ice nu	rse (API	N), physician ass	istant (PA) <mark>(print/type)</mark>			Date
Signature of physician, APN, PA					,		· / u			
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#### ■ PREPARTICIPATION PHYSICAL EVALUATION

## **CLEARANCE FORM**

Name	Sex D M D F Age Date of birth
☐ Cleared for all sports without restriction	
☐ Cleared for all sports without restriction with recommendations for further eval	aluation or treatment for
□ Not cleared	
☐ Pending further evaluation	
☐ For any sports	
☐ For certain sports	
Reason	
Recommendations	
EMERGENCY INFORMATION	
Allergies	
Other information	
Other information	
HCP OFFICE STAMP	SCHOOL PHYSICIAN:
	Reviewed on
	(Date)
	Approved Not Approved
Date of Exam	Signature:
clinical contraindications to practice and participate in the sport(s) and can be made available to the school at the request of the paren	articipation physical evaluation. The athlete does not present apparent as outlined above. A copy of the physical exam is on record in my office its. If conditions arise after the athlete has been cleared for participation, ed and the potential consequences are completely explained to the athle
Name of physician, advanced practice nurse (APN), physician assistant (PA)	Date
	Phone
Signature of physician, APN, PA	
Completed Cardiac Assessment Professional Development Module	
DateSignature	

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