Oracle School District #2

ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

Parent/Guardian should fill out this form with assistance from the student athlete.

Name _____ Sex ____ Age _____ Date of Birth_____ Grade____

Address _____ City_____ Zip_____

Emergency Contact Name _____ Phone (H) _____ (W) _____ (Cell) _____

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

	Yes	No
1. Have you had a medical illness or injury since your last Check-up or sports physical?		
Do have an ongoing or chronic illness?		
Are you currently being treated for an injury or condition?		
2. Have you ever been hospitalized overnight?		
Have you ever had surgery?		
3. Are you currently talking any prescription or nonprescription (over-the-counter) Medications or pills or using an inhaler?		
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?		
4. Do you have any allergies to medications?		
Have you have any allergies to pollen, food or stinging insects?		
Have you ever had a rash or hives develop during or after exercise?		
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?		
Do you get tired more quickly than your friends during exercise?		
Have you ever had racing or your heart or skipped heartbeats?		
Have you had high blood pressure or high cholesterol?		
Have you ever been told you have a heart murmur?		
Have you had a sever viral infection (i.e., mononucleosis or myocarditis) within the last month?		
Has your doctor ever denied or restricted your participation in sports for any heart problems?		
Has anyone in your immediate family had the following conditions: Diabetes_____Heart Disease_____Other_____ Sudden death prior to age 50_____High blood pressure_____		
6. Do you have any current skin problems (for example, itching, rashes, acne warts, fungus, or blisters)?		
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 numbness or tingling in your arms, hands, legs, or feet?		
Have you ever had a seizure?		
Do you have frequent or sever headaches?		
Have you ever had a stinger, burner, or pinched nerve?		
8. Have you ever become ill from exercising in the heat?		

	Yes	No
9. Do you cough, wheeze, or have trouble breathing during or after activity?		
Do you have asthma?		
Do you use an inhaler?		
Do you have seasonal allergies that require medical treatment?		
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 orthotics, retainer on your teeth, hearing aid?		
11. Have you had any problems with your eyes or vision?		
Do you wear glasses, contacts, or protective eyewear?		
12. Have you ever had a sprain, strain, or swelling after injury?		
Have you broken or fractured any bones or dislocated any joints?		
Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?		

If yes, check appropriate box below

☐ Head	☐ Upper Arm	☐Finger	☐Ankle
☐ Neck	☐ Elbow	☐Hip	☐Foot
☐ Back	☐Forearm	☐Thigh	
☐Chest	☐Wrist	☐Knee	
☐Shoulder	☐Hand	☐Shin/Calf	

	Yes	No
13. Do you want to weigh more or less than you do now?		
Do you lose weight regularly to meet weight requirements for your sport?		
14. Do you feel stressed?		
15. Do you , or have you ever used (please check): Alcohol_____ Smokeless tobacco_____ Cigarettes_____ Recreational Drugs_____		

Females Only

16. When was your first menstrual period?		
When was your most recent menstrual period?		
How much time do you usually have from the the start of one period to the start of another?		
How many periods have you had in the last year?		
What was the longest time between periods in the last year?		

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. I understand and acknowledge that truthful and accurate information is essential in properly determining whether the student should be cleared for athletic participation. I hereby consent for the student named above, to be given medical care by the doctor selected by the school.

Student Signature _____ Parent/Guardian Signature_____

Date_____ Date_____

Reverse

Oracle School District #2

ANNUAL PREPARTICIPATION PHYSICAL EXAMINATION

Name: _____ Date: _____

Height: _____ Weight: _____ Pulse: _____ BP: _____

Vision: R20/_____ L20/_____ Glasses/Contacts: Yes ___ No ___ Pupils: Equal _____ Unequal _____

ANNUAL PHYSICAL EXAMINATION

	NORMAL	ABNORMAL FINGINGS	INITIALS*
Medical			
Appearance			
Skin			
Eyes/Ears/Nose			
Throat/Oropharynx			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia/Hernia			
Musculoskeletal			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*Station-based examination only

List immunizations given today: _____

CLEARANCE

Cleared _____

Cleared after completing evaluation/rehabilitation for:

_____

Not Cleared for _____ **Reason:** _____

Recommendations: _____

_____

Name of physician (print/type) _____ **Date** _____

Address _____ **Telephone** _____

Signature of physician _____ **MD / DO / NP / PA-C**