

ALABAMA HIGH SCHOOL ATHLETIC ASSOCIATION

Preparticipation Physical Evaluation

History

Date _____

Name _____ Sex _____ Age _____ Date of birth _____

Address _____ Phone _____

School _____ Grade _____ Sport _____

Explain "Yes" answers below:

	Yes	No
1. Have you ever been hospitalized?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery?.....	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you presently taking any medications or pills?.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have any allergies (medicine, bees or other stinging insects)?.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever passed out during or after exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been dizzy during or after exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had chest pain during or after exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you tire more quickly than your friends during exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had high blood pressure?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been told that you have a heart murmur?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had racing of your heart or skipped heartbeats?.....	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone in your family died of heart problems or a sudden death before age 50?.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any skin problems (itching, rashes, acne)?.....	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had a head injury?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been knocked out or unconscious?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a seizure?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a stinger, burner or pinched nerve?.....	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had heat or muscle cramps?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been dizzy or passed out in the heat?.....	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have trouble breathing or do you cough during or after activity?.....	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)?.....	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you had any problems with your eyes or vision?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear glasses or contacts or protective eye wear?.....	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you had any other medical problems (infectious mononucleosis, diabetes, etc.)?.....	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you had a medical problem or injury since your last evaluation?.....	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints.	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Head <input type="checkbox"/> Back <input type="checkbox"/> Shoulder <input type="checkbox"/> Forearm <input type="checkbox"/> Hand <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Ankle		
<input type="checkbox"/> Neck <input type="checkbox"/> Chest <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Finger <input type="checkbox"/> Thigh <input type="checkbox"/> Shin <input type="checkbox"/> Foot		
14. When was your first menstrual period? _____		
When was your last menstrual period? _____		
What was the longest time between your periods last year? _____		

Explain "Yes" answers:

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

Date _____

Signature of athlete _____

Signature of parent/guardian _____

DUPLICATE AS NEEDED

Preparticipation Physical Evaluation

Rule 1, Sec. 13 — No student shall be eligible to represent his/her school in interscholastic athletics unless there is on file in the Superintendent's or Principal's office a physician's statement for the current year certifying that the student has passed an adequate physical examination, and that in the opinion of the examining physician he/she is fully able to participate in high school athletics.

Physical Examination

COMPLETE	LIMITED	Height _____ Weight _____ BP _____ / _____ Pulse _____		
		Vision R 20 / _____ L 20 / _____ Corrected: Y N		
			Normal	Abnormal findings
		Cardiovascular		
		Pulses		
		Heart		
		Lungs		
		Skin		
		E.N.T.		
		Abdominal		
		Genitalia (males)		
		Musculoskeletal		
		Neck		
		Shoulder		
		Elbow		
		Wrist		
		Hand		
		Back		
		Knee		
		Ankle		
Foot				
Other				

Clearance:

- A. Cleared
- B. Cleared after completing evaluation/rehabilitation for: _____
- C. Not cleared for: ☐ Collision ☐ Contact ☐ Noncontact _____ Strenuous _____ Moderately strenuous _____ Nonstrenuous

Due to: _____

Recommendation: _____

Name of physician _____ Date _____

Address _____ Phone _____

Signature of physician _____, M.D. or D.O.