

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"/> |
| <b>12. Have you had a medical problem or injury since your last evaluation?.....</b>   | <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.