PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: ___________________________ Date of birth: ___________________________

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of ____________________________________________________________________________________
                                                                                       ____________________________________________________________________________________

☐ Medically eligible for certain sports ____________________________________________________________________________________
                                                                                       ____________________________________________________________________________________

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations: ____________________________________________________________________________________
                                                                                       ____________________________________________________________________________________

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): ___________________________ Date: ___________________________

Address: __________________________________________________________________ Phone: ___________________________

Signature of health care professional: ____________________________________________, MD, DO, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies: ____________________________________________________________________________________
                                                                                       ____________________________________________________________________________________
                                                                                       ____________________________________________________________________________________

Medications: ____________________________________________________________________________________
                                                                                       ____________________________________________________________________________________
                                                                                       ____________________________________________________________________________________
                                                                                       ____________________________________________________________________________________

Other information: ____________________________________________________________________________________
                                                                                       ____________________________________________________________________________________
                                                                                       ____________________________________________________________________________________
                                                                                       ____________________________________________________________________________________

Emergency contacts: ____________________________________________________________________________________
                                                                                       ____________________________________________________________________________________
                                                                                       ____________________________________________________________________________________
                                                                                       ____________________________________________________________________________________

Supplemental COVID-19 questions

1. Have you had any of the following symptoms in the past 14 days?  
   a) Fever or chills   Yes / No  
   b) Cough           Yes / No  
   c) Shortness of breath or difficulty breathing Yes / No  
   d) Fatigue         Yes / No  
   e) Muscle or body aches Yes / No  
   f) Headache        Yes / No  
   g) New loss of taste or smell Yes / No  
   h) Sore throat     Yes / No  
   i) Congestion or runny nose Yes / No  
   j) Nausea or vomiting Yes / No  
   k) Diarrhea        Yes / No  
   l) Date symptoms started ________  
   m) Date symptoms resolved ________  

2. Have you ever had a positive test for COVID-19?  Yes / No  
   If yes:  
   i. Date of test ________  
   ii. Were you tested because you had symptoms? Yes / No  
       If yes:  
       a) Date symptoms started ________  
       b) Date symptoms resolved ________  
       c) Were you hospitalized? Yes / No  
       d) Did you have fever > 100.4 F.? Yes / No  
          If yes, how many days did your fever last? ________  
       e) Did you have muscle aches, chills, or lethargy? Yes / No  
          If yes, how many days did these symptoms last? ________  
   iii. Were you tested because you were exposed to someone with COVID-19,  but you did not have any symptoms? Yes / No  

3. Has anyone living in your household had any of the following symptoms or tested positive for COVID-19 in the past 14 days? Yes / No  
   If Yes, circle the applicable symptoms.  
   • Fever or chills  
   • Shortness of breath or difficulty breathing  
   • Muscle or body aches  
   • New loss of taste or smell  
   • Nausea or vomiting  
   • Congestion or runny nose  
   • Sore throat  
   • Headache  
   • Cough  
   • Fatigue  
   • Diarrhea  

4. Have you been within 6 feet for more than 15 minutes of someone with COVID-19 in the past 14 days? Yes / No  
   If yes: date(s) of exposure ________  

5. Are you currently waiting on results from a recent COVID test? Yes / No  

Sources:  
- Interim Guidance on the Preparticipation Physical Examination... : Clinical Journal of Sport Medicine (lww.com)  
- Supplemental COVID-19 Questions (lww.com)  
- COVID-19 Interim Guidance: Return to Sports and Physical Activity (aap.org)
PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: ________________________________________________________________
Date of examination: _____________________________ Sport(s): _____________________________
Date of birth: _____________________________ Sex assigned at birth (F, M, or intersex): ____________
How do you identify your gender? (F, M, or other): _____________________________

List past and current medical conditions. ________________________________________________________________
Have you ever had surgery? If yes, list all past surgical procedures. ________________________________________________________________
Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional). ________________________________________________________________
Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects). ________________________________________________________________

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

<table>
<thead>
<tr>
<th>Feeling anxious, or on edge</th>
<th>Not at all</th>
<th>Several days</th>
<th>Over half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Not being able to stop or control worrying</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS
(Explain “Yes” answers at the end of this form. Circle questions if you don’t know the answer.)

Yes No
1. Do you have any concerns that you would like to discuss with your provider?
2. Has a provider ever denied or restricted your participation in sports for any reason?
3. Do you have any ongoing medical issues or recent illness?

HEART HEALTH QUESTIONS ABOUT YOU

Yes No
4. Have you ever passed out or nearly passed out during or after exercise?
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?
7. Has a doctor ever told you that you have any heart problems?
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)

Yes No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?
10. Have you ever had a seizure?

HEART HEALTH QUESTIONS ABOUT YOUR FAMILY

Yes No
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?
### Bone and Joint Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Do you have a bone, muscle, ligament, or joint injury that bothers you?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Medical Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>16. Do you cough, wheeze, or have difficulty breathing during or after exercise?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?</td>
<td></td>
<td></td>
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<tr>
<td>20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Have you ever become ill while exercising in the heat?</td>
<td></td>
<td></td>
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<tr>
<td>23. Do you or does someone in your family have sickle cell trait or disease?</td>
<td></td>
<td></td>
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<tr>
<td>24. Have you ever had or do you have any problems with your eyes or vision?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. Do you worry about your weight?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. Are you trying to or has anyone recommended that you gain or lose weight?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. Are you on a special diet or do you avoid certain types of foods or food groups?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. Have you ever had an eating disorder?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Females Only

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>29. Have you ever had a menstrual period?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. How old were you when you had your first menstrual period?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31. When was your most recent menstrual period?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32. How many periods have you had in the past 12 months?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Explain “Yes” answers here.**

______________________________________________________  
______________________________________________________  
______________________________________________________  
______________________________________________________  

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: ____________________________________________  
Signature of parent or guardian: ________________________________  
Date: ____________________________

PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: __________________________________________  Date of birth: ______________

PHYSICIAN REMINDERS

1. Consider additional questions on more-sensitive issues.
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?

2. Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION

Height: ______  Weight: ______

BP: ______/______ Pulse: ______  Vision: R 20/□  L 20/□  Corrected: □ Y □ N

MEDICAL

Appearance
- Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)

Eyes, ears, nose, and throat
- Pupils equal
- Hearing

Lymph nodes

Heart
- Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)

Lungs

Abdomen

Skin
- Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant Staphylococcus aureus (MRSA), or tinea corporis

Neurological

MUSCULOSKELETAL

Neck

Back

Shoulder and arm

Elbow and forearm

Wrist, hand, and fingers

Hip and thigh

Knee

Leg and ankle

Foot and toes

Functional
- Double-leg squat test, single-leg squat test, and box drop or step drop test

*Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): ______________________________________  Date: ______________

Address: ________________________________________________________________________  Phone: __________________________

Signature of health care professional: _____________________________________________________________________, MD, DO, NP, or PA