



Madrid Waddington Central School Preparticipation Physical Evaluation

History

Date of exam _____

Name _____ Sex _____ Age _____ Date of birth _____

Grade _____ School _____ Sport(s) _____

Address _____ Phone _____

Personal physician _____

In case of an emergency, contact

Name _____ Relationship _____ Phone (H) _____ (W) _____

Explain "Yes" answers below. Circle the number
If you don't know the answers.

	Yes	No		Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical? Do you have an on going or chronic illness?	___	___	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)?	___	___
2. Have you ever been hospitalized overnight? Have you ever had surgery?	___	___	11. Have you had any problems with you eyes or vision? Do you wear glasses, contacts, or protective eyewear?	___	___
3. Are you currently taking 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?	___	___	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 and explain below.	___	___
4. Do you have any allergies (for example, to Pollen, medicine, food, or stinging insects)? Have you ever had a rash or hives develop During or after exercise?	___	___	___ Head ___ Elbow ___ Hip ___ Neck ___ Forearm ___ Thigh ___ Back ___ Wrist ___ Knee ___ Chest ___ Hand ___ Shin/Calf ___ Shoulder ___ Finger ___ Ankle ___ Foot ___ Upper arm		
5. Have you ever passed out during or after Exercise? Have you ever been dizzy during or after Exercise? Do you get tired more quickly than your Friends do during exercise? Have you ever had racing of your heart or Skipped heartbeats? Have you had high blood pressure or high cholesterol? Have you ever been told you have a heart murmur? Had any family member or relative died of heart problems or of sudden death before age 50? Have you had a severe viral infection (for example myocarditis or mononucleosis) within the last month? Has a physician ever denied or restricted your participation in sports for any heart problems?	___	___	13. Do you want to weigh more or less than you do now? Do you lose weight regularly to meet weight requirements for your sports? 14. Do you feel stressed out? 15. Record the dates of your most recent immunizations (shots) for:	___	___
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	___	___	Tetanus _____ Measles _____ Hepatitis B _____ Chickenpox _____		
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 a seizure? Do you have frequent or severe headaches? Have you ever had numbness or tingling in your arms, hands, legs, or feet? Have you ever had a stinger, burner, or pinched nerve?	___	___	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 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? _____		
8. Have you ever became ill from exercising in the heat?	___	___	Explain "Yes" answers here: _____ _____ _____ _____ _____		
9. Do you cough, wheeze, or have trouble breathing during or after activity? Do you have asthma? Do you have seasonal allergies that require medical treatment?	___	___	I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Signature of athlete _____ Signature of parent/guardian _____ Date _____		

Preparticipation Physical Evaluation

PHYSICAL EXAMINATION

Name _____ Date of birth _____
 Height _____ Weight _____ %Body fat (optional) _____ Pulse _____ BP / ____ (____/____, ____/____)
 Vision R20/____ L20/____ Corrected: Y N Pupils: Equal _____ Unequal _____

	Normal	Abnormal findings	Initials*
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
Foot			

*Station-based examination only

CLEARANCE

Cleared
 Cleared after completing evaluation/rehabilitation for: _____

Not cleared for: _____ Reason: _____

Recommendations: _____

Name of Physician (print/type) _____ Date _____
 Address _____ Phone _____
 Signature of physician _____ MD or DO

