Pre-Participation Physical Evaluation

(This page to be completed by physician/nurse practitioner/physician assistant)

PHYSICAL EXAMINATION DATE OF EXAM _____

NAME _____ DATE OF BIRTH _____

HEIGHT _____ WEIGHT _____ % BODY FAT (optional) _____ PULSE _____ BP _____

VISION R 20/ _____ L 20/ _____ CORRECTED? Y _____ N _____ PUPILS: EQUAL _____ UNEQUAL _____

	NORMAL	ABNORMAL FINDING	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 [Sport(s)]: _____ Reason: _____

Recommendation: _____

_____

_____

Name of physician/nurse practitioner/physician assistant _____ Date: _____
(PRINT OR TYPE)

Address: _____ Phone: _____

Signature of physician/nurse practitioner/physician assistant _____

PHYSICIANS STAMP:

Endorsed by the MPSSAA

Pre-Participation Physical Evaluation

HISTORY
This page to be completed by student and parent/guardian

Name _____ Sex _____ Age _____ Date of Birth _____
Grade _____ School _____ Sport(s) _____
Address _____
Personal physician _____
In case of emergency, contact
Name _____ Relationship _____ Phone (H) _____ (W) _____

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

	YES	NO
1. Have you had a medical illness or injury since your last check up or sports physical?	❑	❑
Do you have an ongoing or chronic illness?	❑	❑
2. Have you ever been hospitalized overnight?	❑	❑
Have you ever had surgery?	❑	❑
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?	❑	❑
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?	❑	❑
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 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?	❑	❑
Has 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?	❑	❑
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 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?	❑	❑
8. Have you ever become ill from exercising in the heat?	❑	❑
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?	❑	❑

	YES	NO
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 bone, 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.

❑ Head	❑ Upper arm	❑ Hand	❑ Knee
❑ Back	❑ Elbow	❑ Finger	❑ Shin/calf
❑ Chest	❑ Forearm	❑ Hip	❑ Ankle
❑ Shoulder	❑ Wrist	❑ Thigh	❑ Foot

	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 out?	❑	❑

15. Record the dates of your most recent immunizations (shots) for:
Tetanus _____ Measles _____
Hepatitis B _____ Chickenpox _____

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? _____

Explain "Yes" answers here: _____

We hereby state that, to the best of our knowledge, our answers to the above questions are complete and correct.
Signature of athlete _____ Signature of parent/guardian _____ Date _____

PRE-PARTICIPATION COVID-19
Supplemental Questions for Student's Physical

This form should be completed by the student's physician at the time of a physical.

Student History

1. Has your child or adolescent been diagnosed with COVID-19?

Yes No

2. Was your child or adolescent hospitalized as a result for complications of COVID-19?

Yes No

3. Has your Child been diagnosed with Multi-inflammatory Syndrome in Children?

Yes No

4. Has your child or adolescent had direct known exposure to someone diagnosed with COVID-19?

Yes No

Please address any "yes" answers to the above questions here:

_____

_____

_____

_____

_____

_____