



PRE-PARTICIPATION HISTORY AND PHYSICAL EXAMINATION

Name: _____ Birth Date: _____ Grade: _____ Exam Date: _____
Print Full Name

Address: _____ City: _____ Zip: _____

Phone: _____ Sport: _____ M: [] F: []

Parents/Guardians: Must complete reverse side before physical appointment

MEDICAL AUTHORITIES LICENSED TO GIVE PHYSICAL EXAMINATIONS: (circle)

1. Medical Doctor (MD) 2. Certified Nurse Practitioner (CRN) 3. Naturopaths (ND) 4. Doctor of Osteopathy (DO) 5. Medics-Physician Assistant (PA)

Age: _____ Pulse: _____

↓ This Section Optional ↓

Height: _____ Blood Pressure: _____

Urinalysis: Body Fat% HCT:

Weight: _____ Visual Acuity: Left: 20/_____ Right: 20/_____

Normal

- 1. Head
2. Eyes (pupils), ENT
3. Teeth
4. Chest
5. Lungs
6. Heart
7. Abdomen
8. Genitalia
9. Neurological
10. Skin
11. Physical Maturity
12. Spine, Back
13. Shoulders, Upper extremities
14. Lower extremities

Abnormal

- Blank lines for abnormal findings

Assessment:

- Full participation
Limited participation (describe limitations, restrictions):
Life threatening condition (severe asthma, bee/food allergy) requires medication order before participation. (please attach the information/medication orders)

- Participation contradicted (list reasons):

Recommendations (equipment, taping, rehabilitation, etc.):

EXAMINER'S CERTIFICATION

Authorized examiners are medical authorities licensed to give medical examinations. (WIAA 18.13.1)

I hereby certify that the above-named individual is physically qualified to participate in all interscholastic athletic activities NOT CROSSED OUT BELOW:

- Baseball Basketball Bowling Cheerleading Cross Country Drill Team Football Golf
Gymnastics Soccer Softball Swimming Tennis Volleyball Wrestling Track

Wrestling Weight Permit: Circle Lowest Weight Classifications Permissible

Senior High 103 112 119 125 130 135 140 145 152 161 171 189 215 275
Junior High 75 80 85 90 95 100 105 110 115 120 125 130 135 140 152 162 172 185 Unlimited(must be over 185)

Date: _____

Examiner's Signature: _____

Examiner's Phone: () _____

Print Examiner's Name: _____

PRE-PARTICIPATION HISTORY

- | | Yes | No | |
|--------|--------------------------|--------------------------|--|
| 1. a. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any illness/injury recently, or do you have an illness/injury now? |
| b. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had a medical problem, illness or injury since your last exam? |
| c. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any chronic or recurrent illness? |
| d. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any illness lasting more than a week? |
| e. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been hospitalized overnight? |
| f. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any surgery other than tonsillectomy? |
| g. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any injuries requiring treatment by a physician? |
| h. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any organ missing other than tonsils (appendix, eye, kidney, testicle, etc.)? |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | Are you presently taking ANY medications (including birth control pills, vitamins, aspirin, etc.)? |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have ANY allergies (medicines, bees, foods, or other factors)? |
| 4. a. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had chest pain, dizziness, faintness, passing out during or after exercise? |
| b. | <input type="checkbox"/> | <input type="checkbox"/> | Do you tire more easily or quickly than your friends during exercises? |
| c. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any problem with your blood pressure or your heart? |
| d. | <input type="checkbox"/> | <input type="checkbox"/> | Have any close relatives had heart problems, heart attack or sudden death before they were age 50? |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any skin problems (acne, itching, rashes, etc.)? |
| 6. a. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had fainting, convulsions, seizures or severe dizziness? |
| b. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have frequent severe headaches? |
| c. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a "stinger" or "burner" or "pinched nerve"? |
| d. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been "knocked out" or "passed out"? |
| e. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a neck or head injury? |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had heat exhaustion, heat stroke, heat cramps or similar heat-related problems? |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had asthma, or trouble breathing, or cough during or after exercise? |
| 9. a. | <input type="checkbox"/> | <input type="checkbox"/> | Do you wear eyeglasses, contact lenses or protective eye wear? |
| b. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any problems with your eyes or vision? |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | Do you wear any dental appliances such as braces, bridge, plate, retainer? |
| 11. a. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a knee injury? |
| b. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had an ankle injury? |
| c. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever injured any other joint (shoulder, wrist, fingers, etc.)? |
| d. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a broken bone (fracture)? |
| e. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a cast, splint, or had to use crutches? |
| f. | <input type="checkbox"/> | <input type="checkbox"/> | Must you use special equipment for competition (pads, braces, neck roll, etc.)? |
| 12. | <input type="checkbox"/> | <input type="checkbox"/> | Has it been more than 5 years since your last tetanus booster shot? |
| 13. | <input type="checkbox"/> | <input type="checkbox"/> | Are you worried about your weight? |
| 14. | <input type="checkbox"/> | <input type="checkbox"/> | FEMALES: Have you any menstrual problems? |
| 15. | <input type="checkbox"/> | <input type="checkbox"/> | Have you any medical concerns about participating in your sport? |

Recommendations
