■ PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name:		
PHYSICIAN REMINDERS	Date of birth:	
 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?
- Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
- 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?
- Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

	VINATIO	N								
Heigh	ıt:				Weight:					
BP:	/	(/)	Pulse:	Vision: R 20/	L 20/	Correc	ted: 🗆 Y	□ N
MED	ICAL								NORMAL	ABNORMAL FINDING
• M		•			osis, high-arched p [MVP], and aorti	palate, pectus excavatum, ara ic insufficiency)	chnodactyly, hyper	rlaxity,		
• Pu	ears, no upils equ earing		throat	t						
Lympl	h nodes									
Heart	-a									
• M	urmurs (ausculta	ation s	tandii	ng, auscultation s	upine, and ± Valsalva maneuv	ver)			
Lungs										
Abdo	men									
tir	nea corp		us (HS)	V), les	ions suggestive of	f methicillin-resistant Staphylod	coccus aureus (MRS	A), or		
	ological	CLETAL							NORMAL	ARNORMAL FINDING
Neck	CULOSK	ELETAL							NORMAL	ABNORMAL FINDING
Back				-						
	der and	arm			$\overline{}$					
	and for									
	, hand, a	_	arc							
_	nd thigh	na mig	213							
Knee										
	nd ankle									
	and toes									
Funct	ional			7						
• Do	ouble-leg	squat t	est, sii	ngle-le	eg squat test, and	box drop or step drop test				
	der elect		ograp	hy (E0	CG), echocardiogr	raphy, referral to a cardiologi	st for abnormal car	diac histo	ry or examina	ition findings, or a comb
Name	of health	care pro	ofessio	onal (p	orint or type):				Date:	
Addres										
Signati	ure of he	alth car	e prof	fessio	nal:					, MD, DO, NP, o

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■ PREPARTICIPATION PHYSICAL EVALUATION MEDICAL ELIGIBILITY FORM

Name:	Date of birth:	
□ Medically eligible for all sports without restriction	Date of birtii.	
$\hfill\Box$ Medically eligible for all sports without restriction with recommendations for furt	ther evaluation or treatment of	
		
□ Medically eligible for certain sports		
		_
□ Not medically eligible pending further evaluation		
□ Not medically eligible for any sports		
Recommendations:	\longrightarrow)
examination findings are on record in my office and can be made available tarise after the athlete has been cleared for participation, the physician may and the potential consequences are completely explained to the athlete (a	rescind the medical eligibility until the p	
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:		

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■ PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

lame:	
rate of examination:	Sport(s):
ex 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 sur	gical procedures.
Medicines and supplements: List all current presc	riptions, over-the-counter medicines, and supplements (herbal and nutritional).
Do you have any allergies? If yes, please list all you	r allergies (ie, medicines, pollens, food, stinging insects).

Patient Health Questionnaire Version 4 (PHQ-4) Over the last 2 weeks, how often have you been bothe	red by any of t	the following prob	lems? (Circle response.)
	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
(A sum of ≥3 is considered positive on either sub-	scale [questio	ns 1 and 2, or ques	tions 3 and 4] for scree	ening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
Do you have any concerns that you would like to discuss with your provider?		
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	Yes	No
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?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		
MEDICAL QUESTIONS	Yes	No
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
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?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease?		
24. Have you ever had or do you have any prob- lems with your eyes or vision?		

MEDICAL QUESTIONS (CONTINUED)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		
FEMALES ONLY	Yes	No
29. Have you ever had a menstrual period?		
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		
32. How many periods have you had in the past 12		

	•	•	•	

COVID-19

- A current physical MUST be on file. CHSAA recommends this PPE form.
 - o COVID-19 specific questions should be included in the physical screening to include:
 - 1. Have you tested positive for COVID-19?
 - 2. Have you had any known exposure to a COVID-19 positive individual?
 - **3.** Have you been tested for COVID-19?
 - **4.** Have you had any new onset of cough or shortness of breath?
 - 5. Have you experienced any recent temperature greater than 100.3°
 - The most recent medical evidence recommends consideration of cardiac testing if a student athlete has
 previously tested positive for COVID-19. This should be discussed with the team physician on a case-by-case
 basis.

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:	
	-