

# PREPARTICIPATION PHYSICAL EVALUATION (Page 1 of 4)

*This medical history form should be retained by the healthcare provider and/or parent.*

*This form is valid for 365 calendar days from the date signed below.*

## MEDICAL HISTORY FORM

**o @** (to be completed by student and parent) *print legibly*

Student's Full Name: \_\_\_\_\_ Biological Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_ / \_\_\_ / \_\_\_

School: \_\_\_\_\_ Grade in School: \_\_\_\_\_ Sport(s): \_\_\_\_\_

Home Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_ E-mail: \_\_\_\_\_

Person to Contact in Case of Emergency: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Emergency Contact Cell Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Other Phone: (\_\_\_\_) \_\_\_\_\_

Family Healthcare Provider: \_\_\_\_\_ City/State: \_\_\_\_\_ Office Phone: (\_\_\_\_) \_\_\_\_\_

List past and current medical conditions

Have you ever had surgery? If yes, please list all surgical procedures and dates:

Medicines and supplements (please list all current prescription medications, over-the-counter medicines, and supplements (herbal and nutritional):

Do you have any allergies? If yes, please list all of your allergies (i.e., medicines, pollens, food, insects):

h = j h=j #

or hopeless	0	1	2	3

8-V-k° Qj y-α@Vo Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.		Yes	No	=- ° ku'=- ° Q=j y-α@Vo° "\yu' \y		'	No
1	Do you have any concerns that you would like to discuss with your provider?			8	Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography (ECHO)?		
2	Has a provider ever denied or restricted your participation in sports for any reason?			9	Do you get light-headed or feel shorter of breath than your friends during exercise?		
3	Do you have any ongoing medical issues or recent illnesses?			10	Have you ever had a seizure?		
=- ° ku'=- ° Q=j y-α@Vo° "\yu' \y		'	No	=- ° ku'=- ° Q=j y-α@Vo° "\yu' \yk 7 U @		'	No
4	Have you ever passed out or nearly passed out during or after exercise?			11	Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age		
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?						



# PREPARTICIPATION PHYSICAL EVALUATION (Page 2 of 4)

*This medical history form should be retained by the healthcare provider and/or parent.*

*This form is valid for 365 calendar days from the date signed below.*



k

Student's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_ / \_\_\_ / \_\_\_ School: \_\_\_\_\_

" \ V- " V) K @uj y-α@Vo		'	No
14	Have you ever had a stress fracture?		
15	Did you ever injure a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
16	Do you have a bone, muscle, ligament, or joint injury that currently bothers you?		
U-) @° Qj y-α@Vo		'	No
17	Do you cough, wheeze, or have difficulty breathing during or after exercise or has a provider ever diagnosed you with asthma?		
18	Are you missing n c v		

U-) @° Qj y-α@Vo		'	No
26	Do you worry about your weight?		
27	Are you trying to or has anyone recommended that you gain or lose weight?		
28	Are you on a special diet or do you avoid certain types of foods or food groups?		
29	Have you ever had an eating disorder?		

u . . . . .



**PREPARTICIPATION PHYSICAL EVALUATION (Page 3 of 4)**  
*This medical history form should be retained by the healthcare provider and/or parent.  
 This form is valid for 365 calendar days from the date signed below.*



k

**PHYSICAL EXAMINATION FORM**

Student's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_ / \_\_\_ / \_\_\_ School: \_\_\_\_\_

**HEALTHCARE PROFESSIONAL REMINDERS:**

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?	• Have you experienced performance changes, felt fatigued, and/or experienced times of low energy during the past year?

Verify completion of Assessment and/or Testing



PREPARTICIPATION PHYSICAL EVALUATION (Page 4 of 4)

oy" U @'u=@U-) @\* O-08@00' 7\kU u\ u=- o#=\ \ O

This form is valid for 365 calendar days from the date signed below.



k

U-) @\* O-08@00' 7\kU

o @ (to be completed by student and parent) print legibly

Student's Full Name: \_\_\_\_\_ Biological Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_ / \_\_\_ / \_\_\_

School: \_\_\_\_\_ Grade in School: \_\_\_\_\_ Sport(s): \_\_\_\_\_

Home Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_ E-mail: \_\_\_\_\_

Person to Contact in Case of Emergency: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Emergency Contact Cell Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Other Phone: (\_\_\_\_) \_\_\_\_\_

Family Healthcare Provider: \_\_\_\_\_ City/State: \_\_\_\_\_ Office Phone: (\_\_\_\_) \_\_\_\_\_

- 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 only certain sports as listed below: \_\_\_\_\_

Not medically eligible for any sports

Recommendations: \_\_\_\_\_

I hereby certify that I, or a clinician under my direct supervision, have examined the above-named student-athlete using the FHSAA EL2 Preparation Physical Evaluation and have provided the conclusion(s) listed above. A copy of the exam has been retained and can be accessed by the parent as

o @ (to be completed by student and parent) *print legibly*  
Student's Full Name: \_\_\_\_\_ Biological Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_ / \_\_\_ / \_\_\_  
School: \_\_\_\_\_ Grade in School: \_\_\_\_\_ Sport(s): \_\_\_\_\_  
Home Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_  
Name of Parent/Guardian: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Person to Contact in Case of Emergency: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_  
Emergency Contact Cell Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Other Phone: (\_\_\_\_) \_\_\_\_\_