

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

Student Informat on (to be Student's Full Name:	completed by student and	d parent) <i>print legibly</i> Sex Assigr	ned at Birth: Age: I School: Sport(s): Home Phone: ()	Date of Birth: / /	
School:		Grade in S	School:Sport(s):		
Home Address:	Ci	ty/State:	Home Phone: ()		
Name of Parent/Guardian:					
Person to Contact in Case of E	mergency:	Relat onship	to Student:		
Emergency Contact Cell Phone): ()	Work Phone: () Other Phone: City/State: Of ce Phone:		()	
Family Healthcare Provider:		Uty/State:	Or ce Phone:	()	
List past and current medical o	conditions:				
Have you ever had surgery? If	yes, please list all surgical pro	ocedures and dates:			
Medicines and supplements (p	olease list all current prescrip	t on medicat ons, over-the-c	counter medicines, and supplem	nents (herbal and nutrit onal):	
Do you have any allergies? If y	es, please list all of your aller	gies (i.e., medicines, pollens	, food, insects):		
Pat ent Health Quest onaire v Over the past two weeks, how		ed by any of the following pr	oblems? (Girde response)		
	Not at all	Several days	Over half of the days	Nearly everyday	
Feeling nervous, anxious, or on edge	0	1	2	3	
Not being able to stop or control worrying	0	1	2	3	
Lit le interest or pleasure in doing things	0	1	2	3	
Feeling down, depressed, or hopeless	0	1	2	3	

exercise?

Have you ever had discomfort, pain, t ghtness, or pressure in 5 your chest during exercise?

Doesyourhearteverr

Α Α had an unexpected or unexplained sudden death before age 35? (including drowning or unexplained car crash)

Doesanyone in your family have a genet cheart problem such as hypertrophic cardiomyopathy (HCM), Marfan Syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminerigc polymorphic ventricular tachycardia (CPVT)?

Has anyone in your family had a pacemaker or an implanted def brillator before age 35?

This form is not considered valid unless all sections are complete.



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.



______ Date of Birth: ___ /___ /____ School: _____ Student's Full Name:

	ant 31 dii Nume.		
BON	IE AND JOINT QUESTIONS	Yes	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 pract ce or game?		
16	Do you have a bone, muscle, ligament, or joint injury that currently bothers you?		
MEDICAL QUESTIONS		Yes	No
17	Do you cough, wheeze, or have dif culty breathing during or af er exercise or has a provider ever diagnosed you with asthma?		
18	Are you missing a kidney, an eye, a test de, your spleen, or any other organ?		
19	Do you have groin or test de pain or a painful bulge or hemia in the groin area?		
20	Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant staphylococcus aureus (MRSA)?		
21	Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
22	Have you ever had numbness, had t ngling, had weakness in your arms or legs, or been unable to move your arms or legs af er being hit or falling?		
23	Have you ever become ill while exercising in the heat?		
24	Do you or does someone in your family have sickle cell trait or disease?		
25	Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (cont nued)		Yes	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 eat ng disorder?		

This form is not considered valid unless all sect ons are complete.

Part cipat on in high school sports is not without risk. The student-athlete and parent/guardian acknowledge truthful answers to the above quest ons allows for a trained clinician to assess the individual student-athlete against risk factors associated with sports-related



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.



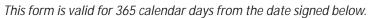
PHYSICAL EXAMINATION FORM

Student's Full Name:	Date of Birth: / School:		
PHYSICIAN REMINDERS: Consider addit onal quest ons on more sensit ve 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, snuf , 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? 			
Verify complet on of FHSAA EL2 Medical History (pages 1 and 2), review these medical history responses as part of your assessment. Cardiovascular history/symptom quest ons include Q4-Q13 of Medical History form. (check box if complete)			
EXAMINATION			
Height: Weight:			
BP: / (/) Pulse: Vision: R 20/	L 20/ Corrected: Yes No		

Student Informat on (to be completed by student and parent) print legibly



PREPARTICIPATION PHYSICAL EVALUATION (Supplement) SUBMIT THIS MEDICAL ELIGIBILITY FORM TO THE SCHOOL





MEDICAL ELIGIBILITY FORM - Referred Provider Form

Student Informat on (to be completed by stu	ident and parent) print legibly		
Student's Full Name:			Date of Birth: / /
School:	Grade	e in School: Sport(s):	
Home Address:			
Name of Parent/Guardian:	E-mail:	·	
Person to Contact in Case of Emergency:	Relat on	ship to Student:	
Emergency Contact Cell Phone: ()		Other Pho	one: ()
Family Healthcare Provider:	City/State:	Of ce Pho	one: ()