



Archdiocese of Miami
 Department of Schools
Athletic Pre-participation Physical Evaluation (Page 1 of 2)
 This completed form must be kept on file by the school

Part 1. Student Information (to be completed by the parent).

Student Name: _____ Sex: _____ Age _____ Date of Birth ____/____/____

School: _____ Grade in School _____ Sport(s) expected to play _____

Home Address: _____ Home Phone () _____

Name of Parent/Guardian: _____

Person to Contact in Case of Emergency: _____

Relationship to Student: _____ Home Phone: () _____ Work Phone: () _____

Personal Family Physician: _____ City/State: _____ Office Phone: () _____

Part 2. Medical History (to be completed by parent). Explain "yes" answers below. Circle questions for which you do not know the answer

- | | Yes | No | | Yes | No |
|--|-------|-------|--|-------------------|---------------|
| 1. Has child had a medical illness or injury since the last check up or sports physical? | _____ | _____ | 26. Has child ever become ill from exercising in the heat? | _____ | _____ |
| 2. Does child have an ongoing chronic illness? | _____ | _____ | 27. Does child cough, wheeze or have trouble breathing during or after activity? | _____ | _____ |
| 3. Has child ever been hospitalized overnight? | _____ | _____ | 28. Does child have asthma? | _____ | _____ |
| 4. Has child ever had surgery? | _____ | _____ | 29. Does child have seasonal allergies that require medical treatment? | _____ | _____ |
| 5. Is child currently taking any prescription or nonprescription (over the counter) medications or pill or using an inhaler? | _____ | _____ | 30. Does child have 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)? | _____ | _____ |
| 6. Has child ever taken any supplements or vitamins to help gain or lose weight or improve performance? | _____ | _____ | 31. Has child had any problems with his/her eyes or vision? | _____ | _____ |
| 7. Does child have any allergies (for example to pollen, medicine, food or stinging insects)? | _____ | _____ | 32. Does child wear glasses, contacts, or protective eye wear? | _____ | _____ |
| 8. Has child ever had rash or hives develop during or after exercise? | _____ | _____ | 33. Has child ever had a sprain, strain, or swelling after injury? | _____ | _____ |
| 9. Has child ever passed out during or after exercise? | _____ | _____ | 34. Has child broken or fractured any bones or dislocated any joints? | _____ | _____ |
| 10. Has child ever been dizzy during or after exercise? | _____ | _____ | 35. Has child had any other problems with pain or swelling in muscles, tendons, bones, or joints? | _____ | _____ |
| 11. Has child ever had chest pain during or after exercise? | _____ | _____ | <i>If yes, check appropriate blank and explain below:</i> | | |
| 12. Does child get tired more quickly than friends during exercise? | _____ | _____ | ___ Head | ___ Elbow | ___ Hip |
| 13. Has child ever had racing of the heart or skipped heartbeats? | _____ | _____ | ___ Neck | ___ Forearm | ___ Thigh |
| 14. Has child had high blood pressure or high cholesterol? | _____ | _____ | ___ Back | ___ Wrist | ___ Knee |
| 15. Has child ever been told he/she has a heart murmur? | _____ | _____ | ___ Chest | ___ Hand | ___ Shin/Calf |
| 16. Has any family member or relative died of heart problems or sudden death before age 50? | _____ | _____ | ___ Shoulder | ___ Finger | ___ Ankle |
| 17. Has child had severe viral infection (for example, myocarditis or mononucleosis) within the last month? | _____ | _____ | ___ Upper Arm | ___ Foot | |
| 18. Has a physician ever denied or restricted child's participation in sports for any heart problems? | _____ | _____ | 36. Does child want to weigh more or less than child weighs now? | _____ | _____ |
| 19. Does child have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? | _____ | _____ | 37. Does child lose weight regularly to meet weight requirements for a sport? | _____ | _____ |
| 20. Has child ever had a head injury or concussion? | _____ | _____ | 38. Does child feel stressed out? | _____ | _____ |
| 21. Has child ever been knocked out, become unconscious, or lost his/her memory? | _____ | _____ | 39. Record the dates of his/most recent immunizations (shots) for: | | |
| 22. Has child ever had a seizure? | _____ | _____ | Tetanus _____ | Measles: _____ | |
| 23. Does child have frequent or severe headaches? | _____ | _____ | Hepatitis B _____ | Chickenpox: _____ | |
| 24. Has child ever had numbness or tingling in his/her arms, hands, legs, or feet? | _____ | _____ | | | |
| 25. Has child ever had a stinger, burner, or pinched nerve? | _____ | _____ | | | |

Explain "Yes" answers here: _____

I hereby state, to the best of my knowledge, that my answers to the above questions are complete and correct.

Signature of Parent/Guardian _____

Date: _____



Part 3. Physical Examination (to be completed by physician).

Student Name: _____ Date of Birth _____ / _____ / _____

Height: _____ Weight: _____ % Body Fat (optional): _____ Pulse: _____ Blood Pressure: _____ / _____ (_____ / _____, _____ / _____)

Visual Acuity: Right 20/ _____ Left 20/ _____ Corrected: Yes No Pupils: Equal _____ Unequal _____

FINDINGS	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
1. Appearance	_____	_____	_____
2. Eyes/Ears/Nose/Throat	_____	_____	_____
3. Lymph Nodes	_____	_____	_____
4. Heart	_____	_____	_____
5. Pulses	_____	_____	_____
6. Lungs	_____	_____	_____
7. Abdomen	_____	_____	_____
8. Skin	_____	_____	_____
MUSCULOSKELETAL			
9. Neck	_____	_____	_____
10. Back	_____	_____	_____
11. Shoulder/Arm	_____	_____	_____
12. Elbow/Forearm	_____	_____	_____
13. Wrist/Hand	_____	_____	_____
14. Hip/Thigh	_____	_____	_____
15. Knee	_____	_____	_____
16. Leg/Ankle	_____	_____	_____
17. Foot	_____	_____	_____

* - Station-based examination only

ASSESSMENT

_____ Cleared without limitation

_____ Cleared after completing evaluation/rehabilitation for: _____

_____ Not cleared for: _____ Reason: _____

Recommendations: _____

Name of Physician (print or type): _____ Date: _____

Address: _____

Signature of Physician: _____, MD or DO

Based on recommendations developed by the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine and American Osteopathic Academy for Sports Medicine.