

# Preparticipation Physical Evaluation

**HISTORY  
FORM**

DATE OF EXAM \_\_\_\_\_

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_  
 Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_  
 Personal physician \_\_\_\_\_  
**In case of emergency, contact**  
 Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_

**Explain "Yes" answers below.  
Circle questions you don't know the answers to.**

- |   |                          |  |
|---|--------------------------|--|
|   | Yes                      | No   |
| 1. Has a doctor ever denied or restricted your participation in sports for any reason?  | <input type="checkbox"/> | <input type="checkbox"/>                   |
| 2. Do you have an ongoing medical condition (like diabetes or asthma)?  | <input type="checkbox"/> | <input type="checkbox"/>                   |
| 3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?  | <input type="checkbox"/> | <input type="checkbox"/>                   |
| 4. Do you have allergies to medicines, pollens, foods, or stinging insects?   | <input type="checkbox"/> | <input type="checkbox"/>                   |
| 5. Have you ever passed out or nearly passed out DURING exercise?   | <input type="checkbox"/> | <input type="checkbox"/>                   |
| 6. Have you ever passed out or nearly passed out AFTER exercise?  | <input type="checkbox"/> | <input type="checkbox"/>                   |
| 7. Have you ever had discomfort, pain, or pressure in your chest during exercise?   | <input type="checkbox"/> | <input type="checkbox"/>                   |
| 8. Does your heart race or skip beats during exercise?  | <input type="checkbox"/> | <input type="checkbox"/>                   |
| 9. Has a doctor ever told you that you have (check all that apply):   |                          |  |
| <input type="checkbox"/> High blood pressure  |                          | <input type="checkbox"/> A heart murmur    |
| <input type="checkbox"/> High cholesterol   |                          | <input type="checkbox"/> A heart infection |
| 10. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)   | <input type="checkbox"/> | <input type="checkbox"/>                   |
| 11. Has anyone in your family died for no apparent reason?  | <input type="checkbox"/> | <input type="checkbox"/>                   |
| 12. Does anyone in your family have a heart problem?  | <input type="checkbox"/> | <input type="checkbox"/>                   |
| 13. Has any family member or relative died of heart problems or of sudden death before age 50?  | <input type="checkbox"/> | <input type="checkbox"/>                   |
| 14. Does anyone in your family have Marfan syndrome?  | <input type="checkbox"/> | <input type="checkbox"/>                   |
| 15. Have you ever spent the night in a hospital?  | <input type="checkbox"/> | <input type="checkbox"/>                   |
| 16. Have you ever had surgery?  | <input type="checkbox"/> | <input type="checkbox"/>                   |
| 17. Have you ever had an injury, like a sprain, muscle or ligament tear or tendonitis, that caused you to miss a practice or game? If yes, circle affected area below:            | <input type="checkbox"/> | <input type="checkbox"/>                   |
| 18. Have you had any broken or fractured bones, or dislocated joints? If yes, circle below:   | <input type="checkbox"/> | <input type="checkbox"/>                   |
| 19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below: | <input type="checkbox"/> | <input type="checkbox"/>                   |

Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand/fingers	Chest
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/toes

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 20. Have you ever had a stress fracture?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Do you regularly use a brace or assistive device?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Has a doctor ever told you that you have asthma or allergies?                                  | <input type="checkbox"/> | <input type="checkbox"/> |

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 24. Do you cough, wheeze, or have difficulty breathing during or after exercise?                           | Yes                      | No                       |
| 25. Is there anyone in your family who has asthma?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Have you ever used an inhaler or taken asthma medicine?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?             | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Have you had infectious mononucleosis (mono) within the last month?                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Do you have any rashes, pressure sores, or other skin problems?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Have you had a herpes skin infection?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Have you ever had a head injury or concussion?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Have you been hit in the head and been confused or lost your memory?                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Have you ever had a seizure?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Do you have headaches with exercise?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?     | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. Have you ever been unable to move your arms or legs after being hit or falling?                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 37. When exercising in the heat, do you have severe muscle cramps or become ill?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 39. Have you had any problems with your eyes or vision?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 40. Do you wear glasses or contact lenses?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 41. Do you wear protective eyewear, such as goggles or a face shield?                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 42. Are you happy with your weight?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 43. Are you trying to gain or lose weight?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 44. Has anyone recommended you change your weight or eating habits?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 45. Do you limit or carefully control what you eat?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 46. Do you have any concerns that you would like to discuss with a doctor?                                 | <input type="checkbox"/> | <input type="checkbox"/> |

**FEMALES ONLY**

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 47. Have you ever had a menstrual period?                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 48. How old were you when you had your first menstrual period? | _____                    |                          |
| 49. How many periods have you had in the last year?            | _____                    |                          |

Explain "Yes" answers here: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

Signature of athlete \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

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**I hereby give permission for the release of the attached student medical history and the results of the actual physical examination to the school for the purposes of participation in athletics and activities.**

Parent or Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

# Preparticipation Physical Evaluation

## PHYSICAL EXAMINATION FORM

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ % Body fat (optional) \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_ ( \_\_\_\_\_ / \_\_\_\_\_ , \_\_\_\_\_ / \_\_\_\_\_ )

Vision R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ Corrected: Y N Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

### Follow-Up Questions on More Sensitive Issues

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 1. Do you feel stressed out or under a lot of pressure?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you feel safe?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. During the past 30 days, did you use chewing tobacco, snuff, or dip?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. During the past 30 days, have you had at least 1 drink of alcohol?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever taken steroid pills or shots without a doctor's prescription?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever taken any supplements to help you gain or lose weight or improve your performance?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Questions from the Youth Risk Behavior Survey ( <a href="http://www.cdc.gov/HealthyYouth/yrbs/index.htm">http://www.cdc.gov/HealthyYouth/yrbs/index.htm</a> ) on guns, seatbelts, unprotected sex, domestic violence, drugs, etc | <input type="checkbox"/> | <input type="checkbox"/> |

Notes:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

	NORMAL	ABNORMAL FINDINGS	INITIALS*
<b>MEDICAL</b>			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary†			
Skin			
<b>MUSCULOSKELETAL</b>			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

\*Multiple-examiner set-up only.

†Having a third party present is recommended for the genitourinary examination.

Notes:

\_\_\_\_\_

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD or DO

# Preparticipation Physical Evaluation

**CLEARANCE FORM**

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_

Cleared without restriction  
 Cleared, with recommendations for further evaluation or treatment for: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Not cleared for  All sports  Certain sports: \_\_\_\_\_ Reason: \_\_\_\_\_

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

## EMERGENCY INFORMATION

Allergies \_\_\_\_\_

Other Information \_\_\_\_\_

**IMMUNIZATIONS** (eg, tetanus/diphtheria; measles; mumps, rubella; hepatitis A, B; influenza; poliomyelitis; pneumococcal; meningococcal; varicella)

Up to date (see attached documentation)  Not up to date Specify \_\_\_\_\_

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD or DO

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## Proof of Insurance

Freeman School Board policy requires all students that participate in extracurricular athletic programs to be covered by medical insurance. In order for your son/daughter to be eligible to participate, they must have proof of insurance.

We, the parents/guardians understand that the school carries no insurance of any kind to cover medical expenses which may occur from athletic participation and that the school will itself not be responsible for any such expenses. We agree that we have adequate insurance to cover our son/daughter for any medical expenses incurred while participating.

Insurance Company Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

To be completed for students participating in all NSAA activities.



NEBRASKA SCHOOL ACTIVITIES ASSOCIATION (NSAA)  
Student and Parent Consent Form

School Year: 200\_\_-200\_\_ Member School: \_\_\_\_\_  
Name of Student: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

The undersigned(s) are the Student and the parent(s), guardian(s), or person(s) in charge of the above named Student and are collectively referred to as "Parent".

The Parent and Student hereby:

- (1) Understand and agree that participation in NSAA sponsored activities is voluntary on the part of the Student and is a privilege;
- (2) Understand and agree that (a) by this Consent Form the NSAA has provided to the Parent and Student of the existence of potential dangers associated with athletic participation; (b) participation in any athletic activity may involve injury of some type; (c) the severity of such injury can range from minor cuts, bruises, sprains, and muscle strains to more serious injuries to the body's bones, joints, ligaments, tendons, or muscles, to catastrophic injuries to the head, neck and spinal cord, and on rare occasions, injuries so severe as to result in total disability, paralysis and death; and, (d) even the best coaching, the use of the best protective equipment and strict observance of rules, injuries are still a possibility;
- (3) Consent and agree to participation of the Student in NSAA activities subject to all NSAA by-laws and rules interpretations for participation in NSAA sponsored activities, and the activities rules of the NSAA member school for which the Student is participating; and,
- (4) Consent and agree to (a) the disclosure by the Member School at which the Student is enrolled to the NSAA, and subsequent disclosure by the NSAA, of information regarding the Student, including the student's name, address, telephone listing, electronic mail address, photograph, date of and place of birth, major fields of study, dates of attendance, grade level, enrollment status (e.g., full-time or part-time), participation in officially recognized activities and sports, weight and height of as a member of athletic teams, degrees, honors and awards received, statistics regarding performance, records or documentation related to eligibility for NSAA sponsored activities, medical records, and any other information related to the Student's participation in NSAA sponsored activities; and, (b) the Student being photographed, video taped, audio taped, or recorded by any other means while participating in NSAA activities and contests, consent to and waive any privacy rights with regard to the display of such recordings, and waive any claims of ownership or other rights with regard to such photographs or recordings or to the broadcast, sale or display of such photographs or recordings.

I acknowledge that I have read paragraphs (1) through (4) above, understand and agree to the terms thereof, including the warning of potential risk of injury inherent in participation in athletic activities.

DATED this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
Name of Student [Print Name]

\_\_\_\_\_  
Student Signature

(I am)(We are) the Student's [circle appropriate choice] (Parent) (Guardian). (I)(We) acknowledge that (I)(We) have read paragraphs (1) through (4) above, understand and agree to the terms thereof, including the warning of potential risk of injury inherent in participation in athletic activities. Having read the warning in paragraph (3) above and understanding the potential risk of injury to my Student, (I)(we) hereby give (my)(our) permission for \_\_\_\_\_ [insert student name] to practice and compete for the above named high school in activities approved by the NSAA, **except those crossed out below:**

Baseball	Golf	Tennis	Play Production	Basketball	Swimming/Diving
Track	Football	Speech	Cross Country	Soccer	Volleyball
Music	Softball	Wrestling	Debate	Journalism	

DATED this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
Parent [Print Name]

\_\_\_\_\_  
Parent Signature