PRE-PARTICIPATION PHYSICAL EXAMINATION FORM (Pages 1 & 2)

This form should be completed by the student and parent PRIOR to the physical examination.
Pages 1 and 2 should be retained by the healthcare professional and/or parent and NOT turned into the school.
This form is valid for 365 calendar days from the date signed by the health care professional.

MEDICAL HISTORY FORM— Student Information (to be completed by student and parent) *print legibly*

Student's Full Name _____ Gender: _____ Age: _____ Date of Birth: ___ / ___ / _____

School: _____ Grade: _____ 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 your allergies (i.e., medicines, pollens, food, insects):

_____

Over the past two weeks, how often have you been bothered by any of the following problems (circle 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
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3

	GENERAL QUESTIONS Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.	**Yes**	**No**
1	Do you have any concerns that you would like to discuss with your provider?		
2	Has a provider ever denied or restricted your participation in sports for any reason?		
3	Do you have any ongoing medical issues or recent illnesses?		
	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? (electrocardiography, ECG, or echocardiography, EKG)		
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? (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), ventricular tachycardia (CPVT)?		
13	Has anyone in our family had a pacemaker or an implant defibrillator before age 35?		

PRE-PARTICIPATION PHYSICAL EXAMINATION FORM (Pages 1 & 2)

This form should be completed by the student and parent PRIOR to the physical examination.
Pages 1 and 2 should be retained by the healthcare professional and/or parent and NOT turned into the school.
This form is valid for 365 calendar days from the date signed by the health care professional.

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

BONE AND JOINT QUESTIONS		Yes	No
14	Have you ever had a stress fracture?		
15	Did you ever injure a bone, muscle, joint, or tendon that caused you to miss a practice or a 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 difficulty breathing during or after exercise or has a provider ever diagnosed you with asthma?		
18	Are you missing a kidney, an eye, a testicle, your spleen, or another organ?		
19	Do you have groin or testicle pain or a painful bulge or hernia 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, prolonged headache, or memory problems?		
22	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?		
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?		
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	Do you have an eating disorder?		
Explain "Yes" answers here:			

Participation in middle school sports is not without risk.The student-athlete and parent/guardian acknowledge truthful answers to the above questions allows for a trained clinician to assess the individual student-athlete against risk factors associated with sports-related injuries and death. This preparticipation physical evaluation shall be completed each year before participating in interscholastic athletic competition or engaging in any practice, tryout, workout, conditioning, or other physical activity, including activities that occur outside of the school year.
We hereby state, to the best of our knowledge, that our answers to the above questions are complete and correct. No pupil shall participate in formal practice or represent his/her/their school in middle school athletics until this form is completed in its entirety and page 3 and 4 is on file with the principal or athletic director signed by his/her/their parents or legal guardian and a practitioner license in the United States to perform sports physicals certifying that: (a) he/she/they has passed an adequate physical examination within the past 365 calendar days; (b) that in the opinion of the examining licensed practitioner, he/she/they is physically fit to participate in middle school athletes. The CHSAA Sports Medicine Advisory Committee strongly recommends a medical evaluation with your healthcare provider for risk factors of sudden cardiac arrest which may include the special tests listed above.

Student-Athlete Name: (printed) _____ Student-Athlete Signature: _____ Date:__/__/____

Parent/Guardian Name: (printed) _____ Parent/Guardian Signature: _____ Date:__/__/____
Parent/Guardian Name: (printed) _____ Parent/Guardian Signature: _____ Date:__/__/____

PRE-PARTICIPATION PHYSICAL EXAMINATION FORM (Pages 3 & 4)

This form should be completed by the health care professional at the time of the examination.

Pages 1 and 2 should be retained by the healthcare professional. ONLY Pages 3 and 4 should be turned into the school.

This form is valid for 365 calendar days from the date signed by the health care professional.

PHYSICAL EXAMINATION FORM

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

PHYSICIAN 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?
Have you ever taken any supplements to help you gain or lose weight or improve your performance?	
Have you ever taken anabolic steroids or used any other performance-enhancing supplement?	

☐ Verify completion of Medical History (pages 1 and 2), review these medical history responses as part of your assessment.

☐ Cardiovascular history/symptom questions include Q4-Q13 of Medical History form. (check if complete)

EXAMINATION

Height: **Weight:**

BP: / (/) **Pulse:** **Vision: R20/** **L20/** **Corrected: Yes No**

MEDICAL - Healthcare professional shall initial each assessment	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfanstigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse (MVP), and aortic insufficiency)		
Eyes, Ears, Nose and Throat • Pupils Equal • Hearing		
Lymph Nodes		
Heart • Murmurs (auscultation standing, auscultations supine, and Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes Simplex Virus (HSV), lesions suggestive of Methicillin-Resistant Staphylococcus Aureus (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL -Healthcare professional shall initial each assessment	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder and Arm		
Elbow and Forearm		
Wrist, Hand, and Fingers		
Hip and thigh		
Knee		
Leg and Ankle		
Foot and Toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

Name of Healthcare Professional (print or type)_____ Date of Exam: ____/____/____

Address: _____ Phone: (___) _____ E-mail: _____

Signature of Healthcare Professional: _____ Credentials: _____ License #: _____

PRE-PARTICIPATION PHYSICAL EXAMINATION FORM (Pages 3 & 4)

This form should be completed by the health care professional at the time of the examination. Pages 1 and 2 should be retained by the healthcare professional. ONLY Pages 3 and 4 should be turned into the school.

This form is valid for 365 calendar days from the date signed by the health care professional.

MEDICAL ELIGIBILITY FORM

Student Information (to be completed by student and parent) *print legibly*

Student's Full Name _____ Gender: _____ Age: ____ Date of Birth: ___ / ___/ _____

School: _____ Grade: _____ 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:
(use additional sheet, if necessary)
_____

☐ Medically eligible for only certain sports as listed below:
_____

☐ Not medically eligible for any sports
Recommendations: (use additional sheet, if necessary)
_____

I hereby certify that I have examined the above-named student-athlete using the Poudre School District Pre-Participation Physical Evaluation forms and have provided the conclusion(s) listed above. A copy of the exam has been retained and can be accessed by the parent as requested. Any injury or other medical conditions that arise after the date of this medical clearance should be properly evaluated, diagnosed, and treated by an appropriate healthcare professional prior to participation in activities.

Name of Healthcare Professional (print or type)_____ Date of Exam: ____/____/____

Address: _____ Phone: (___) _____ E-mail: _____

Signature of Healthcare Professional: _____ Credentials: _____ License #: _____

SHARED EMERGENCY INFORMATION: completed at the time of assessment by the practitioner and parent

☐ Check this box if there is not relevant medical history to share related to participation in competitive sports.

Provider Stamp (if required by school)

Medications: (use additional sheet, if necessary)
List: _____
_____
_____

Relevant medical history to be reviewed by athletic trainer/team physician: (explain below, use additional sheet, if necessary)

_____ Allergies _____ Asthma _____ Cardiac/Heart _____ Concussion _____ Diabetes
_____ Heat Illness _____ Surgical History _____ Sickle Cell Trait _____ Mental Health

Explain:_____
_____
_____

Student Signature: _____ Date ____/____/____

Signature of Parent/Guardian Name: _____ Date: ____/____/____

We hereby state, to the best of our knowledge, the information recorded on this form is complete and correct.

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