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
1. Has child had a medical illness or injury since the last check up or sports physical?		
2. Does child have an ongoing chronic illness?		
3. Has child ever been hospitalized overnight?		
4. Has child ever had surgery?		
5. Is child currently taking any prescription or nonprescription (over the counter) medications or pill or using an inhaler?		
6. Has child ever taken any supplements or vitamins to help gain or lose weight or improve performance?		
7. Does child have any allergies (for example to pollen, medicine, food or stinging insects)?		
8. Has child ever had rash or hives develop during or after exercise?		
9. Has child ever passed out during or after exercise?		
10. Has child ever been dizzy during or after exercise?		
11. Has child ever had chest pain during or after exercise?		
12. Does child get tired more quickly than friends during exercise?		
13. Has child ever had racing of the heart of skipped heartbeats?		
14. Has child had high blood pressure or high cholesterol?		
15. Has child ever been told he/she has a heart murmur?		
16. Has any family member or relative died of heart problems or sudden death before age 50?		
17. Has child had severe viral infection (for example, myocarditis or mononucleosis) within the last month?		
18. Has a physician ever denied or restricted child's participation in sports for any heart problems?		
19. Does child have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?		
20. Has child ever had a head injury or concussion?		
21. Has child ever been knocked out, become unconscious, or lost his/her memory?		
22. Has child ever had a seizure?		
23. Does child have frequent or severe headaches?		
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?		

	Yes	No
26. Has child ever become ill from exercising in the heat?		
27. Does child cough, wheeze or have trouble breathing during or after activity?		
28. Does child have asthma?		
29. Does child have seasonal allergies that require medical treatment?		
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)?		
31. Has child had any problems with his/her eyes or vision?		
32. Does child wear glasses, contacts, or protective eye wear?		
33. Has child ever had a sprain, strain, or swelling after injury?		
34. Has child broken or fractured any bones or dislocated any joints?		
35. Has child had any other problems with pain or swelling in muscles, tendons, bones, or joints?		

If yes, check appropriate blank and explain below:

___ *Head*	___ *Elbow*	___ Hip
___ Neck	___ Forearm	___Thigh
___ Back	___ Wrist	___Knee
___ Chest	___ Hand	___Shin/Calf
___ Shoulder	___ Finger	___ Ankle
___ Upper Arm	___ Foot	

	Yes	No
36. Does child want to weigh more or less than child weighs now?		
37. Does child lose weight regularly to meet weight requirements for a sport?		
38. Does child feel stressed out?		

39. Record the dates of his/most recent immunizations (shots) for:

Tetanus_____ Measles:_____

Hepatitus B_____ Chickenpox:_____

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:_____

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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 OF EXAMINING PHYSICIAN

_____Cleared without limitation

_____Not cleared for_____ Reason_____

_____Cleared after completing evaluation/rehabilitation for:_____

_____Referred to_____ For_____

_____

Recommendations:_____

_____

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

Address:_____

Signature of Physician:_____, MD, DO, DC, ARNP

ASSESSMENT OF PHYSICIAN TO WHOM REFERRED (if applicable)

I hereby certify that the examination(s) for which referred was/were performed by myself or an individual under my direct supervision with the following conclusion(s)

_____Cleared without limitation

_____Not cleared for_____ Reason_____

_____Cleared after completing evaluation/rehabilitation for:_____

_____Referred to_____ For_____

_____

Recommendations:_____

_____

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

Address:_____

Signature of Physician:_____, MD, DO, DC, ARNP

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.