

SALINAS UNION HIGH SCHOOL DISTRICT

SCHOOL: **SALINAS HIGH SCHOOL**

STUDENT ID: _____

PREPARTICIPATION PHYSICAL FORM

YOU WILL NOT BE ALLOWED A PHYSICAL WITHOUT PARENT SIGNATURE AND COMPLETION OF FORM

NAME _____ SEX _____ AGE _____ DATE OF BIRTH _____

GRADE _____ SPORTS _____

Personal Physician _____ Physician's Phone Number _____

Explain "Yes" answers below:

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Have you ever been hospitalized?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever had surgery?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you presently taking any medications or pills?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have any allergies (medicine, bees, or other stinging insects)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever passed out during or after exercise?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever been dizzy during or after exercise?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had chest pain during or after exercise?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you tire more quickly than your friends during exercise?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever had high blood pressure?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever been told that you had a heart murmur?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever had racing of your heart or skipped heartbeats?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Has anyone in your family died of heart problems or a sudden death before age 50?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you have any skin problems (itching, rashes, acne)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you ever had a head injury?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever been knocked out or unconscious?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever had a seizure?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you ever had a stinger, burner or pinched nerve?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you ever had heat or muscle cramps?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you ever been dizzy or passed out in the heat?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Do you have trouble breathing or do you cough after your activity?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Have you had any problems with your eyes or vision?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Do you wear glasses, contacts or protective eye wear?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling
or other injuries of any of the following bones or joints? Mark all that apply..... | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Head <input type="checkbox"/> Shoulder <input type="checkbox"/> Thigh <input type="checkbox"/> Neck <input type="checkbox"/> Knee <input type="checkbox"/> Chest <input type="checkbox"/> Hip | | |
| <input type="checkbox"/> Forearm <input type="checkbox"/> Shin/Calf <input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Hand <input type="checkbox"/> Foot | | |
| 25. Have you had any other medical problems (infectious mononucleosis, diabetes, etc.)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Have you had a medical problem or injury since your last evaluation?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. When was your last tetanus shot? | _____ | |
| 28. When was your last measles immunization?..... | _____ | |
| 29. When was your last menstrual period?..... | _____ | |
| 30. When was your first menstrual period? | _____ | |
| 31. What was the longest time between your periods last year?..... | _____ | |

Explain "Yes" answers: _____

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

Signature of Athlete _____ **Signature of Parent** _____

Date _____ Date _____

FORM MUST BE COMPLETED AND SIGNED BY PARENT AND STUDENT PRIOR TO PHYSICAL

Adapted from Lombardo et al. *Pre-participation Physical Evaluation* (monograph). Kansas City, MO; American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopedic Society for Sports Medicine, American Osteopathic Academy of Sports Medicine, 1992.

Student Name _____

Student ID # _____

PHYSICAL EXAMINATION

Height _____ Weight _____ Blood Pressure _____ / _____ Pulse _____

Vision: Right 20/____ Left 20/____ Corrected: Yes No Pupils _____

	Normal	Abnormal Findings					Initials
	1	2	3	4	5		
Tanner Stage							
Cardiopulmonary							
Pulses							
Heart							
Lungs							
Abdominal							
Genitalia							
ENT							
Skin							
Musculoskeletal							
Neck							
Shoulder							
Elbow							
Wrist							
Hand							
Back							
Knee							
Ankle							
Foot							
Other							

CLEARANCE:

- Cleared
- Cleared after completing evaluation/rehabilitation for: _____
- Noncontact _____ Strenuous _____ Moderately strenuous _____ Nonstrenuous

Due to: _____

Recommendation: _____

Physician's Signature: _____

Date: _____

Address: _____

Phone: _____

Physician's Stamp: