

**CARMEL HIGH SCHOOL**  
**Preparticipation Physical Evaluation**  
**Parent/Guardian Complete**

(Two Sided Form)

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

LOCATION: \_\_\_\_\_

Student's Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

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

Personal Physician \_\_\_\_\_ Phone \_\_\_\_\_

In case of emergency, contact: Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Cell) \_\_\_\_\_

**History**

THIS SECTION IS TO BE CAREFULLY AND ACCURATELY COMPLETED BY THE STUDENT AND HIS/HER PARENT(S) OR LEGAL GUARDIAN(S) BEFORE PARTICIPATION IN INTERSCHOLASTIC ATHLETICS IN ORDER TO HELP DETECT POSSIBLE RISKS.  
ANY "YES" ANSWERS MAY REQUIRE FURTHER MEDICAL EVALUATION WHICH MAY INCLUDE A PHYSICAL EXAMINATION.  
EXPLAIN "YES" ANSWERS IN THE SPACE PROVIDED. CIRCLE ANSWERS YOU DON'T KNOW THE ANSWER TO.

<p><b>1.</b> Has a doctor ever denied or restricted your participation in sports for any reason? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>2.</b> Do you have an ongoing medical condition (like diabetes or _____)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>3.</b> Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>4.</b> Do you have allergies to medicines, pollens, foods, or stinging? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>5.</b> Do you think you are in good health? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>6.</b> Have you ever passed out or nearly passed out DURING? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>7.</b> Have you ever passed out or nearly passed out AFTER? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>8.</b> Have you ever had discomfort, pain, or pressure in your chest during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>9.</b> Does your heart race or skip beats during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>10.</b> Has a doctor ever told you that you have (check all that apply): <input type="checkbox"/> High Blood Pres <input type="checkbox"/> Heart murmur <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Heart Infection</p> <p><b>11.</b> Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>12.</b> Has anyone in your family died for no apparent reason? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>13.</b> Does anyone in your family have a heart problem? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>14.</b> Has any family member or relative died of heart problems or of sudden death before age 50? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>15.</b> Does anyone in your family have Marfan syndrome? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>16.</b> Have you ever spent the night in a hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>17.</b> Have you ever had surgery? Date: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>18.</b> Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>19.</b> Have you had any broken or fractured bones or dislocated joints? If yes, circle below: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>20.</b> 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"/> Yes <input type="checkbox"/> No</p> <table border="1" style="width: 100%; text-align: center; font-size: small;"><tr><td>Head</td><td>Neck</td><td>Shoulder</td><td>Upper Arm</td><td>Elbow</td><td>Forearm</td><td>Hand</td><td>Chest</td><td>Wrist</td></tr><tr><td>Upper back</td><td>Lower back</td><td>Hip</td><td>Thigh</td><td>Knee</td><td>Calf/shin</td><td>Ankle</td><td>Foot toes</td><td>Fingers</td></tr></table> <p><b>21.</b> Have you ever had a stress fracture? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>22.</b> Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>23.</b> Do you regularly use a brace or assistive device? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>24.</b> Has a doctor ever told you that you have asthma or allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand	Chest	Wrist	Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot toes	Fingers	<p><b>25.</b> Do you cough, wheeze, or have difficulty breathing during or after exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>26.</b> Is there anyone in your family who has asthma? who _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>27.</b> Have you ever used an inhaler or taken asthma medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>28.</b> Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>29.</b> Have you had infectious mononucleosis (mono) within the last month? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>30.</b> Do you have any rashes, pressure sores, or other skin problems? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>31.</b> Have you had a herpes skin infection? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>32.</b> Have you ever had a head injury or concussion? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>33.</b> Have you been hit in the head and been confused or lost your memory? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>34.</b> Have you ever had a seizure? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>35.</b> Do you have headaches with exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>36.</b> Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>37.</b> Have you ever been unable to move your arms or legs after being hit or falling? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>38.</b> When exercising in the heat, do you have severe muscle cramps or become ill? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>39.</b> Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>40.</b> Have you had any problems with your eyes or vision? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>41.</b> Do you wear glasses or contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>42.</b> Do you wear protective eyewear, such as goggles or a face shield? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>43.</b> Are you happy with your weight? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>44.</b> Are you trying to gain or lose weight? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>45.</b> Has anyone recommended you change your weight or eating habits? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>46.</b> Do you limit or carefully control what you eat? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>47.</b> Do you have any concerns that you would like to discuss with a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="text-align: center;"><b>FEMALES ONLY</b></p> <p><b>48.</b> Have you ever had a menstrual period? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>49.</b> How old were you when you had your first menstrual period? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>50.</b> How many periods have you had in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Explain "Yes" Answers Here: (Attach additional sheets as needed): _____</p>
Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand	Chest	Wrist											
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot toes	Fingers											

I (we) UNDERSTAND THIS IS ONLY A PRE-PARTICIPATION PHYSICAL SPORTS SCREENING AND IS NOT A FULL PHYSICAL.  
I (we) hereby state, to the best of my (our) knowledge, my (our) answers to the above questions are complete and accurate.

Signature: \_\_\_\_\_  
ATHLETE

Signature: \_\_\_\_\_  
PARENT OR GUARDIAN (If athlete in under 18)

Date: \_\_\_\_\_

Date: \_\_\_\_\_

# CARMEL HIGH SCHOOL

## Preparticipation Physical Examination Form

(Two Sided Form)

The section below is to be completed by physician or staff after history and consent forms are completed.

Students Name \_\_\_\_\_ Birth Date \_\_\_\_\_

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 (Optional)**

1. Do you feel stressed out or under a lot of pressure?
2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?
3. Do you feel safe?
4. Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke?
5. During the past 30 days, did you use chewing tobacco, snuff, or dip?
6. During the past 30 days, have you had at least 1 drink of alcohol?
7. Have you ever taken steroid pills or shots without a doctor's prescription?
8. Have you ever taken any supplements to help you gain or lose weight or improve your performance?
9. Questions from the Youth Risk Behavior Survey (<http://www.cdc.gov/HealthyYouth/yrbs/index.htm>) on guns, seatbelts, unprotected sex, domestic violence, drugs, etc.

Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

MEDICAL	Normal	Abnormal findings	Initials*
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
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.

Notes: \_\_\_\_\_

\_\_\_\_\_

### Clearance

- ☐ 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:

Physician, Physician Asst., or Nurse Practitioner: (print) \_\_\_\_\_ Date: \_\_\_\_\_

If the Physician's Assistant (P.A.) or Advanced Nurse Practitioner (A.N.P.) performed the exam, name and address of collaborating physician or physician group: \_\_\_\_\_

Location of Exam: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of Physician, Physician Asst.: \_\_\_\_\_ State License # \_\_\_\_\_ provide stamp  
or Nurse Practitioner (ONLY)

-OVER-