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)** _____

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 FUTHER MEDICAL EVALUATION WHICH MAY INCLUDE A PHYSICAL EXAMINATION. EXPLAIN "YES" ANSWERS IN THE SPACE PROVIDED. CIRCLE ANSWERS YOU DON'T KNOW THE ANSWER TO.

		Yes	No
1.	Has a doctor ever denied or restricted you participation in sports for any reason?	☐	☐
2.	Do you have an ongoing medical condition (like diabetes or	☐	☐
3.	Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	☐	☐
4.	Do you have allergies to medicines, pollens, foods, or stinging	☐	☐
5.	Do you think you are in good health?	☐	☐
6.	Have you ever passed out or nearly passed out DURING	☐	☐
7.	Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
8.	Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
9.	Does your heart race or skip beats during exercise?	☐	☐
10.	Has a doctor ever told you that you have (check all that apply): ☐ High Blood Pres ☐ Heart murmur ☐ High Cholesterol ☐ Heart Infection	☐	☐
11.	Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)	☐	☐
12.	Has anyone in your family died for no apparent reason?	☐	☐
13.	Does anyone in your family have a heart problem?	☐	☐
14.	Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
15.	Does anyone in your family have Marfan syndrome?	☐	☐
16.	Have you ever spent the night in a hospital?	☐	☐
17.	Have you ever had surgery? Date:	☐	☐
18.	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:	☐	☐
19.	Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	☐	☐
20.	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:	☐	☐

Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand	Chest	Wrist
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot toes	Fingers

21.	Have you ever had a stress fracture?	☐	☐
22.	Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
23.	Do you regularly use a brace or assistive device?	☐	☐
24.	Has a doctor ever told you that you have asthma or allergies?	☐	☐
25.	Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
26.	Is there anyone in your family who has asthma? who _____	☐	☐
27.	Have you ever used an inhaler or taken asthma medicine?	☐	☐
28.	Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
29.	Have you had infectious mononucleosis (mono) within the last month?	☐	☐
30.	Do you have any rashes, pressure sores, or other skin problems?	☐	☐
31.	Have you had a herpes skin infection?	☐	☐
32.	Have you ever had a head injury or concussion?	☐	☐
33.	Have you been hit in the head and been confused or lost your memory?	☐	☐
34.	Have you ever had a seizure?	☐	☐
35.	Do you have headaches with exercise?	☐	☐
36.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
37.	Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
38.	When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
39.	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
40.	Have you had any problems with your eyes or vision?	☐	☐
41.	Do you wear glasses or contact lenses?	☐	☐
42.	Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
43.	Are you happy with your weight?	☐	☐
44.	Are you trying to gain or lose weight?	☐	☐
45.	Has anyone recommended you change your weight or eating habits?	☐	☐
46.	Do you limit or carefully control what you eat?	☐	☐
47.	Do you have any concerns that you would like to discuss with a doctor?	☐	☐
	FEMALES ONLY		
48.	Have you ever had a menstrual period?	☐	☐
49.	How old were you when you had your first menstrual period?	☐	☐
50.	How many periods have you had in the last 12 months?	☐	☐

Explain "Yes" Answers Here: (Attach additional sheets as needed): _____

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: _____ **Signature:** _____

ATHLETE **PARENT OR GUARDIAN (If athlete in under 18)**

Date: _____ **Date:** _____

Rev. 05/10

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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**_____

Heig 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/nc			
Hearing			
Lymph node			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitalia (ma			
Skin			
MUSCULO			
Neck			
Back			
Shoulder/arm			
Elbow/forear			
Wrist/hand/fi			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

*Multiple-examiner sel

Notes: _____

Clearance

□ **Cleared without restriction:** _____

□ **Cleared, with recommendations for further evaluation or treatment for:** _____

□ No □ All S □ Certain sports: _____ Reason: _____

Recommendations: _____

Emergency Information:

Allergies: _____

Other Information: _____

Physician, Physician Asst., or Nurse Practioner: (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**

Nurse Practitioner (ONI

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