

# Pre-Participation Physical Evaluation

Student's Name: _____	ID # _____	School: _____	Date of Exam: _____
Gender: M _____ F _____	Age: _____	DOB: _____	Class : <b>20</b> Sport(s): _____
Home Address: _____		Phone: _____	
Personal Physician's Name: _____			
Emergency Contact: Name _____			
Relationship: _____		Phone: Home _____	Work _____

Check **YES** or **NO** for questions below and **explain any "yes" answers. Circle** questions you don't know the answers to.

	YES	NO
1. Have you had a medical illness or injury since your last check up or sports physical? Do you have an ongoing or chronic illness?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized overnight? Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any prescription or nonprescription medications or using an inhaler? Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? Have you ever had a rash or hives develop during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever passed out or been dizzy during or after exercise? Have you ever had chest pain during or after exercise? Do you get tired more quickly than your friends do during exercise? Have you ever had racing of your heart or skipped heartbeats? Have you ever had high blood pressure or high cholesterol? Have you ever been told you have a heart murmur? Has any family member or relative died of heart problems or of sudden death before age 50? Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have any current skin problems (itching, rashes, acne, warts, fungus, or blisters, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had a head injury or concussion? Have you ever been knocked out, become unconscious or lost your memory? Have you ever had a seizure? Do you have frequent or severe headaches? Have you ever had numbness or tingling in your arms, hands, legs, or feet?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you cough, wheeze, or have trouble breathing during or after an activity? Do you have asthma or seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you use 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 aids, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you wear glasses, contacts, or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you ever had a sprain, strain, or swelling after an injury? Have you broken or fractured any bones or dislocated any joints? Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? If <b>yes</b> , check the appropriate box and explain below: <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Back <input type="checkbox"/> Chest <input type="checkbox"/> Shoulder <input type="checkbox"/> Upper Arm <input type="checkbox"/> Elbow <input type="checkbox"/> Forearm <input type="checkbox"/> Wrist <input type="checkbox"/> Hand <input type="checkbox"/> Finger <input type="checkbox"/> Hip <input type="checkbox"/> Thigh <input type="checkbox"/> Knee <input type="checkbox"/> Shin/Calf <input type="checkbox"/> Ankle <input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you want to weigh more or less than you do now? Do you lose weight regularly to meet weight requirements for your sport?	<input type="checkbox"/>	<input type="checkbox"/>
14. Record the dates of most recent immunizations:    Tetanus: _____    Chickenpox: _____    Measles: _____    Hepatitis B: _____		
15. <b>For Females Only:</b> When was your first menstrual period? _____ When was your most recent menstrual period? _____    How many days between periods? _____		
16. Have you ever tested positive or been diagnosed with COVID-19? If yes, when? <b>YES</b> ____ <b>NO</b> ____ Date positive/diagnosis _____		
<b>Please explain any "YES" answers on the other side of this form</b>		

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

**Athlete's Signature:** \_\_\_\_\_    **Parent's Signature:** \_\_\_\_\_    **Date:** \_\_\_\_\_

HUNTINGTON BEACH UNION HIGH SCHOOL DISTRICT  
**Pre-Participation Physical Evaluation**

**PHYSICAL EXAMINATION**

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_ % of Body Fat (optional): \_\_\_\_\_ Pulse: \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_ ( \_\_\_\_\_ / \_\_\_\_\_ , \_\_\_\_\_ / \_\_\_\_\_ )  
 Vision: R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ Corrected: Y N Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

	Normal	Abnormal Findings	Initials*
<b>MEDICAL</b>			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
<b>MUSCULOSKELETAL</b>			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

\* Station based examination only

**CLEARANCE**

\_\_\_\_\_ Cleared and have reviewed questionnaire on reverse side  
 \_\_\_\_\_ Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_  
 \_\_\_\_\_ Not cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_  
 Recommendations: \_\_\_\_\_

**PHYSICIAN'S ADDRESS AND SIGNATURE**

Name of Physician, NP,PA (print or type): _____ Address: _____ Phone: _____ Date: _____  Signature of Physician: _____ <p style="text-align: center; font-size: small;">MD, DO, Nurse Practitioner, Physician Assistant</p>	<b>Stamp with Name of Doctor                  or Medical Office/Clinic                  (Required to be accepted)</b>
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