2023 GREENVILLE COUNTY REC
Pre-participation Physical Evaluation Form

· Please note that the physical exam must be completed on 1/1/23 or later for a player to be eligible for the fall 2023 Season

Athlete's Name: (print) _____ Sex: _____ Age: _____ Date of Birth:_____

School: _____ Grade: _____ Personal Physician: _____

In Case of Emergency, contact: Name:_____ Phone: _____ Relationship: _____

MEDICAL HISTORY			
Explain "yes" answers in the box below **		**Yes**	**No**
1.	Has a doctor ever denied or restricted your participation in sports for any reason?		
2.	Do you currently have an ongoing medical condition? Asthma Diabetes Other		
3.	Are your currently taking any medication (prescription or over-the-counter), pills or an inhaler?		
4.	Do you have any allergies? (Medicine, bees, food etc.)		
5.	Do you, or anyone in your family, have the sickle cell trait?		
6.	Have you ever had a head injury or had a concussion?		
7.	Have you ever been knocked out, become unconscious, or lost your memory?		
8.	Have you ever had a seizure?		
9.	Have you ever had a heat related injury (heat stroke) or severe muscle cramp with activities?		
10.	Have you ever become ill while exercising in the heat?		
11.	Have you ever been dizzy during or after exercise?		
12.	Have you ever passed out or nearly passed out DURING exercise?		
13.	Have you ever fainted or passed out AFTER exercise?		
14.	Have you had extreme fatigue (been really tired) with exercise (more than your friends)?		
15.	Do you ever have trouble breathing, shortness of breath, wheezing or coughing while exercising?		
16.	Have you ever been diagnosed with Asthma or exercise-induced asthma?		
17.	Have you ever used an inhaler or taken Asthma medicine?		
18.	Has a doctor ever told you that you have high blood pressure?		
19.	Do you have headaches with exercise?		
20.	Has a doctor ever ordered an EKG or other tests for your heart?		
21.	Have you ever been told that you have a heart murmur, high cholesterol, or heart infection?		
22.	Have you ever had discomfort, pain or pressure in your chest during or after exercise?		
23.	Have you ever had racing of your heart or skipped heartbeats?		

24.	Have you ever had a stinger, burner or pinched nerve, or loss of feeling or weakness in your arms or legs?		
25.	Do you have any rashes, pressure sores, or other skin problems now?		
26.	Have you had any problems with your eyes or vision?		
27.	Do you wear contacts or glasses?		
28.	Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injury Of any bones or joints? Head Back Shoulder Forearm Hand Hip Knee Ankle Neck Chest Elbow Wrist Finger Thigh Shin Foot		
29.	2Do you worry about your weight?		
30.	Have you ever been hospitalized or had surgery?		
31.	Have you had a medical problem or injury since your last physical evaluation?		
32.	Has any family member had a sudden, unexpected death before the age of 50?		
33.	Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
***Explain "yes" answers here:*			

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Signature of Athlete:_____ Signature of Parent: _____

Office Use Only:

This Medical History Form was reviewed by: Printed Name_____Date:_____Signed_____

Physical Examination 2023 *(Must be Completed by a Licensed Physician, Physician Assistant, or Nurse Practitioner) *Please note that once this form is given to Greenville County Rec, it will not be returned.**

Athlete's Name_____ Sex: M F Age:____ Date of Birth _____

Height_____ ***Weight*** _____ ***BP*** _____/_____ (____/____) ***Pulse*** _____ ***Vision*** R 20/_____ L20/_____		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart		

Pulses		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin		
Neurologic		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		
Functional		

CLEARANCE

Cleared for all sports without restriction

Cleared after completing evaluation/rehabilitation for: _____

_____

_

NOT CLEARED for participation

Reason:_____

Recommendations:

_____

_

_____

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By this signature, I attest that I have examined the above individual and completed this pre-participation physical including a review of the Medical History.

_____

Physician Name (print):

Address:_____ _____MD DO NP PA Date

_____ Signed:_____ Date of Exam**_____

Phone:_____Physician Office Stamp:

_____ Physician Signature:

**Physical will not be accepted without Physician's Office Stamp and/or Full Physician's Address*
*****Physical Exam must be completed on 1/1/23 or later in order to be accepted***