

**BARTLESVILLE PUBLIC SCHOOLS**  
**PRE-PARTICIPATION PHYSICAL EVALUATION**

(PLEASE PRINT)

DATE OF EXAM:

Last Name :

First Name:

MI:

Date of Birth:

Height:	Weight:	Pulse:	BP: /
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2019-2020 INFORMATION (please circle appropriate grade)

**7            8            9            10            11            12**

<b>MEDICAL</b>	NORMAL FINDINGS	ABNORMAL FINDINGS
Appearance		
Eyes/Ears/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Skin		
<b>MUSCULOSKELETAL</b>		
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		

CLEARANCE

Cleared

Not cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_

Recommendation(s): \_\_\_\_\_

Name & Title of Examiner (Printed): \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Examiner:

**ALL PHYSICALS MUST BE DATED AFTER MAY 1, 2019**

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# MEDICAL HISTORY

Name of Athlete (Print): \_\_\_\_\_

This section is to be carefully 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.

**Explain "YES" answers in the space provided. Circle questions you don't know the answer to.**

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

**I (we) hereby state, to the best of my (our) knowledge, my (our) answers to the above questions are complete and correct:**

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

(Parent and/or Guardian)