# Preparticipation Physical Evaluation

**HISTORY FORM**

**Parent/Guardian Completed**

(Not: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep copy of this form in the chart.)

**Date of Exam**

**Name**

**Sex**

**Age**

**Grade**

**School**

**Sport(s)**

**Medicines and Allergies:** Please list all the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking.

<table>
<thead>
<tr>
<th>Medicines</th>
<th>Allergies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

**Do you have any allergies?**

- Yes
- No

If yes, identify specific allergy below:

- **Medicines**
- **Pollens**
- **Food**
- **Stinging Insects**

**EXPLAIN "YES" ANSWERS BELOW:** Circle questions you don’t know the answers to.

**GENERAL QUESTIONS**

1. Has a doctor ever denied or restricted your participation in sports for any reason?  
2. Do you have any ongoing medical conditions? If so, please identify below:  
   - Asthma
   - Anemia
   - Diabetes
   - Infections
   - Other:

3. Have you ever spent the night in the hospital?  
4. Have you ever had surgery?

**HEART HEALTH QUESTIONS ABOUT YOU**

5. Have you ever passed out or nearly passed out during or after exercise?  
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?  
7. Does your heart rate race or skip beats (irregular beats) during exercise?  
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply:  
   - High blood pressure
   - A heart murmur
   - High cholesterol
   - A heart infection
   - Kawasaki disease
   - Other:

9. Has a doctor ever ordered a test for your heart? (For example, EKG, echo-cardiogram)

10. Do you get lightheaded or feel more short of breath than expected during exercise?

11. Have you ever had an unexplained seizure?

12. Do you get more tired or short of breath more quickly than your friends during exercise?

**HEART HEALTH QUESTIONS ABOUT YOUR FAMILY**

13. Has any family member or relative ever died of heart problems of an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?

14. Does anyone in you family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?

15. Does anyone in you family have a history of heart problems, pacemaker or implanted defibrillator?

16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?

**BONE AND JOINT QUESTIONS**

17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?

18. Have you ever had any broken or fractured bones or dislocated joints?

19. Have you ever had an injury that required x-rays, MRIs, CT scans, injections, therapy, a brace, a cast, or crutches?

20. Have you ever had a stress fracture?

21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (D'wars syndrome or dwarfism)

22. Do you regularly use a brace, orthotics, or other assistive device?

23. Do you have a bone, muscle, or joint injury that bothers you?

24. Do any of your joints become painful, swollen, feel warm, or look red?

25. Do you have any history of juvenile arthritis or connective tissue disease?

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/guardian**

**Date**

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Preparticipation Physical Evaluation
THE ATHLETE WITH SPECIAL NEEDS:
SUPPLEMENTAL HISTORY FORM

Parent/Guardian Completed

Date of Exam

Name __________________________________________ Date of Birth ____________________________

Sex Age Grade School Sports

1. Type of disability
2. Date of disability
3. Classification (if available)
4. Cause of disability (birth, disease, accident/trauma, other)
5. List the sports you are interested in playing

| 6. Do you regularly use a brace, assistive device, or prosthetic? | Yes | No |
| 7. Do you use any special brace or assistive device for sports? |
| 8. Do you have any rashes, pressure sores, or any other skin problems? |
| 9. Do you have a hearing loss? Do you use a hearing aid? |
| 10. Do you have a visual impairment? |
| 11. Do you use any special devices for bowel or bladder function? |
| 12. Do you have burning or discomfort when urinating? |
| 13. Have you had autonomic dysreflexia? |
| 14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness? |
| 15. Do you have muscle spasticity? |
| 16. Do you have frequent seizures that cannot be controlled by medication? |

Explain “yes” answers here

| Please indicate if you have ever had any of the following. | Yes | No |
| Athetosis or instability |
| X-ray evaluation for athetosis instability |
| Dislocated joints (more than one) |
| Easy bleeding |
| Enlarged spleen |
| Hepatitis |
| Osteopenia or osteoporosis |
| Difficulty controlling bowel |
| Difficulty controlling bladder |
| Numbness or tingling in arms or hands |
| Numbness or tingling in legs or feet |
| Weakness in arms or hands |
| Weakness in legs or feet |
| Recent change in coordination |
| Recent change in ability to walk |
| Spina bifida |
| Latex allergy |

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/guardian __________________________ Date __________


New Jersey Department of Education 2014; Pursuant to P.L. 2013, c. 71
# Preparticipation Physical Evaluation

**Physical Examination Form**

**Name:** ____________________________  **Date of birth:** ______________

## PHYSICIAN REMINDERS

1. **Consider additional questions on more sensitive issues**
   - *Do you feel stressed out or under a lot of pressure?*
   - *Do you ever feel sad, hopeless, depressed, or anxious?*
   - *Do you feel safe at your home or residence?*
   - *Have you ever tried cigarettes, chewing tobacco, snuff, or dip?*
   - *During the past 30 days, did you use chewing tobacco, snuff, or dip?*
   - *Do you drink alcohol or use any other drugs?*
   - *Have you ever taken anabolic steroids or used any other performance supplement?*
   - *Have you used any supplements to help you gain or lose weight or improve your performance?*
   - *Do you wear a seat belt, use a helmet, and use condoms?*

2. **Consider reviewing questions on cardiovascular symptoms (questions 9–14).**

### EXAMINATION

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
</table>

| BP    | ( ) | Pulse | Vision R 20/ | L 20/ | Corrected | Y | N |

### MEDICAL

#### Normal

- **Appearance**
  - Marfan syndrome (kypohosphaticosis, high-arched palate, pectus excavatum, arachnodactylyy, arm span > height, hypertelorism, myopia, MVP, aortic insufficiency)

- **Eyes/ears/nose/throat**
  - Pupils equal
  - Hearing

- **Lymph nodes**

- **Heart**
  - Murmurs (auscultation standing, supine, +/- Valsalva
  - Location of point of maximal impulse (PMI)

- **Pulses**
  - Simultaneous femoral and radial pulses

- **Lungs**

- **Abdomen**

- **Genitourinary (males only)**

- **Skin**
  - HSV, lesions suggestive of MRSA, tinea corporis

- **Neurologic**

### MUSCULOSKELETAL

- **Neck**

- **Back**

- **Shoulder/arm**

- **Elbow/forearm**

- **Wrist/hand/fingers**

- **Hip/thigh**

- **Knee**

- **Leg/ankle**

- **Foot/toes**

- **Functional**
  - Duck-walk, single leg hop

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- **Clear for all sports without restriction**
- **Clear for all sports without restriction with recommendations for further evaluation or treatment for**

- **Not cleared**
  - Pending further evaluation
  - For any sports
  - For certain sports

### Recommendations

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) (print/type)  **Date of exam** ______________

Signature of physician, APN, PA  **Address**: ____________________________  **Phone:** ______________

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Preparticipation Physical Evaluation
CLEARANCE FORM

Name ___________________________ Sex □ M □ F Age __________ Date of birth __________

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for ______________________________

☐ Not cleared

☐ Pending further evaluation

☐ For any sports

☐ For certain sports

Reason ______________________________

Recommendations __________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

EMERGENCY INFORMATION

Allergies ______________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

Other information __________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

HCP OFFICE STAMP

SCHOOL PHYSICIAN:

Reviewed on ____________ (Date)

Approved ______ Not Approved ______

Signature: __________________________

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) ____________ Date __________

Address ____________________________ Phone ____________________________

Signature of physician, APN, PA ____________________________

Completed Cardiac Assessment Professional Development Module

Date __________ Signature __________


New Jersey Department of Education 2014, Pursuant to P.L.2013, c.71