Archdiocese of Miami
Department of Schools
Athletic Pre-participation Physical Evaluation (Page 1 of 2)
This completed form must be kept on file by the school

MUST BE COMPLETED BY PARENTS

Part 1. Student Information (to be completed by the parent).

Student Name:____ Sex:_______ Age________ Date of Birth_______/_______/_______

School:___________________________________ Grade in School_______ Sport(s) expected to play____

Home Address:____ Home Phone ( )___________________________

Name of Parent/Guardian:____

Person to Contact in Case of Emergency:____

Relationship to Student:___________________________Home Phone: ( )_______________________ Work Phone: ( )_______________________

Personal/Family Physician:________________________ City/State:_________________________________ Office Phone: ( )__________________

Part 2. Medical History (to be completed by parent). Explain "yes" answers below. Circle questions for which you do not know the answer

	Yes	No
1. Has child had a medical illness or injury since the last check up or sports physical?	_____	_____
2, Does child have an ongoing chronic illness?	_____	_____
3. Has child ever been hospitalized overnight?	_____	_____
4. Has child ever had surgery?	_____	_____
5. Is child currently taking any prescription or nonprescription (over the counter) medications or pill or using an inhaler?	_____	_____
6. Has child ever taken any supplements or vitamins to help gain or lose weight or improve performance?	_____	_____
7. Does child have any allergies (for example to pollen, medicine, food or stinging insects)?	_____	_____
8. Has child ever had rash or hives develop during or after exercise?	_____	_____
9. Has child ever passed out during or after exercise?	_____	_____
10. Has child ever been dizzy during or after exercise?	_____	_____
11. Has child ever had chest pain during or after exercise?	_____	_____
12. Does child get tired more quickly than friends during exercise?	_____	_____
13. Has child ever had racing of the heart of skipped heartbeats?	_____	_____
14. Has child had high blood pressure or high cholesterol?	_____	_____
15. Has child ever been told he/she has a heart murmur?	_____	_____
16. Has any family member or relative died of heart problems or sudden death before age 50?	_____	_____
17. Has child had severe viral infection (for example, myocarditis or mononucleosis) within the last month?	_____	_____
18. Has a physician ever denied or restricted child's participation in sports for any heart problems?	_____	_____
19. Does child have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	_____	_____
20. Has child ever had a head injury or concussion?	_____	_____
21. Has child ever been knocked out, become unconscious, or lost his/her memory?	_____	_____
22. Has child ever had a seizure?	_____	_____
23. Does child have frequent or severe headaches?	_____	_____
24. Has child ever had numbness or tingling in his/her arms, hands, legs, or feet?	_____	_____
25. Has child ever had a stinger, burner, or pinched nerve?	_____	_____

	Yes	No
26. Has child ever become ill from exercising in the heat?	_____	_____
27. Does child cough, wheeze or have trouble breathing during or after activity?	_____	_____
28. Does child have asthma?	_____	_____
29. Does child have seasonal allergies that require medical treatment?	_____	_____
30. Does child have 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 aid)?	_____	_____
31. Has child had any problems with his/her eyes or vision?	_____	_____
32. Does child wear glasses, contacts, or protective eye wear?	_____	_____
33. Has child ever had a sprain, strain, or swelling after injury?	_____	_____
34. Has child broken or fractured any bones or dislocated any joints?	_____	_____
35. Has child had any other problems with pain or swelling in muscles, tendons, bones, or joints?	_____	_____

If yes, check appropriate blank and explain below:

___ *Head*	___ *Elbow*	___ Hip
___ Neck	___ Forearm	___Thigh
___ Back	___ Wrist	___Knee
___ Chest	___ Hand	___Shin/Calf
___ Shoulder	___ Finger	___ Ankle
___ Upper Arm	___ Foot	

	Yes	No
36. Does child want to weigh more or less than child weighs now?	_____	_____
37. Does child lose weight regularly to meet weight requirements for a sport?	_____	_____
38. Does child feel stressed out?	_____	_____

39. Record the dates of his/most recent immunizations (shots) for:

Tetanus__________________ Measles:___________________

Hepatitus B_______________ Chickenpox:________________

Explain "Yes" answers here: ____

____

____

____

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

Signature of Parent/Guardian____ Date:_______________________________________

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(MUST COMPLETED & DATED BY PHYSICIAN)

Part 3. Physical Examination (to be completed by physician).

Student Name:____ Date of Birth_______/_______/_______

Height: __________ Weight: __________ % Body Fat (optional):___________ Pulse:_________ Blood Pressure: _____/_____ (_____/_____ , _____/_____)

Visual Acuity: Right 20/_____ Left 20/_____ Corrected: Yes No Pupils: Equal__________ Unequal __________

FINDINGS	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
1. Appearance	___________	______________________________	________________
2. Eyes/Ears/Nose/Throat	___________	______________________________	________________
3. Lymph Nodes	___________	______________________________	________________
4. Heart	___________	______________________________	________________
5. Pulses	___________	______________________________	________________
6. Lungs	___________	______________________________	________________
7. Abdomen	___________	______________________________	________________
8. Skin	___________	______________________________	________________
MUSCULOSKELETAL			
9. Neck	___________	______________________________	________________
10. Back	___________	______________________________	________________
11. Shoulder/Arm	___________	______________________________	________________
12. Elbow/Forearm	___________	______________________________	________________
13. Wrist/Hand	___________	______________________________	________________
14. Hip/Thigh	___________	______________________________	________________
15. Knee	___________	______________________________	________________
16. Leg/Ankle	___________	______________________________	________________
17. Foot	___________	______________________________	________________

* - Station-based examination only

ASSESSMENT OF EXAMINING PHYSICIAN

_____Cleared without limitation

_____Not cleared for____ Reason____________________________

_____Cleared after completing evaluation/rehabilitation for:____

_____Referred to____ For____________________________

____

Recommendations:____

____

Name of Physician (print or type):____ Date:____________________

Address:____

Signature of Physician:____, MD, DO, DC, ARNP

ASSESSMENT OF PHYSICIAN TO WHOM REFERRED (if applicable)

I hereby certify that the examination(s) for which referred was/were performed by myself or an individual under my direct supervision with the following conclusion(s)

_____Cleared without limitation

_____Not cleared for____ Reason____________________________

_____Cleared after completing evaluation/rehabilitation for:____

_____Referred to____ For____________________________

____

Recommendations:____

____

Name of Physician (print or type):____ Date:____________________

Address:____

Signature of Physician:____, MD, DO, DC, ARNP

Based on recommendations developed by the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine and American Osteopathic Academy for Sports Medicine.