PRE-PARTICIPATION PHYSICAL EVALUATION FORM

This side of form MUST be complete for every participant with parent signature

Name ____ Sex _________ Age _________ Date of Birth _______________

Address ____

Grade ________ Sport(s) ____

Personal Physician ____________________________________ Physician Phone ________________________________

In case of emergency, contact:
Name ___________________________________ Relationship _______________ Phone (H) ___________ (W) _________

Explain "YES" answers below. Circle questions you do not know answers to.

YES NO

1. Have you ever had a medical illness or injury since you last check up or sports physical?
2. Have you ever been hospitalized overnight?
3. Have you ever had surgery?
4. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?
   a. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?
5. Do you have any food allergies (for example: to pollen, medicine, food or stinging insects)?
6. Have you ever passed out during or after exercise?
   a. Have you ever been dizzy during or after exercise?
   b. Have you ever had chest pain during or after exercise?
   c. Do you get tired more quickly than your friends do during exercise?
   d. Have you ever had racing of your heart or skipped heartbeats?
   e. Have you had high blood pressure or high cholesterol?
   f. Have you ever been told you have a heart murmur?
   g. Has any family member or relative died of heart problems or of sudden death before age 50?
   h. Have you had a severe viral infection (for example: myocarditis or mononucleosis) within the last month?
   i. Has a physician ever denied or restricted your participation in sports for any heart problems?
7. Do you have any current skin problems (for example: itching, rashes, acne, warts, fungus or blisters)?
8. Have you ever had a head injury or concussion?
   a. Have you ever been knocked out, become unconscious or lost your memory?
   b. Have you ever had a seizure?
   c. Do you have frequent or severe headaches?
   d. Have you ever had numbness or tingling in your arms, hands, legs or feet?
   e. Have you ever had a stinger, burner or pinched nerve?
9. Have you ever become ill from exercising in the heat?
10. Do you cough, wheeze or have trouble breathing during or after activity?
    a. Do you have asthma?
    b. Do you have seasonal allergies that require medical treatment?
11. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example: knee braces, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?
    Yes **No**
12. Have you had any problems with your eyes or vision?
    Yes **No**
13. Do you wear glasses, contacts or protective eyewear?
    Yes **No**
14. Have you ever had a sprain, strain or swelling after injury? **Yes** **No**
    a. Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?
    Yes **No**
    If yes, check appropriate box and explain below:

Head	Elbow	Hip
Neck	Forearm	Thigh
Back	Wrist	Knee
Chest	Hand	Shin
Shoulder	Finger	Calf
Arm	Ankle	Foot

15. Current Health Insurance Information:

Company: ____________________________________

Address: _____________________________________

Policy #: _____________________________________

In Name Of: __________________________________

Send Claim To: __________ Phone: ______________

Explain **"YES"** answers here: __________________

____

____

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

Signature of Athlete ________________________

Sign. of Parent/Guardian ____________________

Date ____

ZION LUTHERAN SCHOOL PHYSICAL FORM

Name ____ Date of Birth ______________________________

Height _______ Weight . Pulse _________ BP (_________/______:______/______)

Vision R 20/____ L 20/___ Corrected: Y __ N __ Pupils: Equal ___ Unequal ____ Date of Exam

	NORMAL	ABNORMAL FINDINGS
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle/Foot		

CLEARANCE

Cleared

Cleared after completing evaluation/rehabilitation for: ____

____

____

____

____

Not cleared for: _________________________________ Reason: ____________________________________

Recommendations: ____

____

____

____

____

Name of Physician (print/type) : ____ Date: _____________

Address: ____ Phone: ____________

Signature of Physician: ____

This form should be used for all athletes, OR, a copy of a current school physical attached:

PHYSICIAN'S SIGNATURE REQUIRED