ARCHBISHOP MITTY HIGH SCHOOL **PREPARTICIPATION PHYSICAL EVALUATION**

Name _____ Grade 9 10 11 12 Date of Birth_____ Sex M F
Address _____ City/Zip _____ Phone _____
Emergency Contact _____ Relationship_____
Home Phone _____ Work Phone _____ Mobile Phone _____
Personal Physician _____ Phone _____
Address _____ City _____ Zip Code _____
Hospital preference (in case of emergency) _____
Insurance Company _____ Group/Policy # _____ Type (circle one) HMO PPO
Intended Sport(s)_____

Explain "Yes" answers below.
Circle questions you don't know the answers to.

	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2. Do you have an ongoing medical condition (like diabetes or asthma)?	☐	☐
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	☐	☐
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐
5. Have you ever passed out or nearly passed out DURING exercise?	☐	☐
6. Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
8. Does your heart race or skip beats during exercise?	☐	☐
9. Has a doctor ever told you that you have (check all that apply): ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection		
10. Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram)	☐	☐
11. Has anyone in your family died for no apparent reason?	☐	☐
12. Does anyone in your family have a heart problem?	☐	☐
13. Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
14. Does anyone in your family have Marfan syndrome?	☐	☐
15. Have you ever spent the night in a hospital?	☐	☐
16. Have you ever had surgery?	☐	☐
17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below:	☐	☐
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	☐	☐
19. 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:	☐	☐

Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/ Fingers	Chest
Upper Back	Lower Back	Hip	Thigh	Knee	Calf/ Shin	Ankle	Foot/ Toes

20. Have you ever had a stress fracture?	☐	☐
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
22. Do you regularly use a brace or assistive device?	☐	☐
23. Has a doctor ever told you that you have asthma or allergies?	☐	☐
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
25. Is there anyone in your family who has asthma?	☐	☐
26. Have you ever used an inhaler or taken asthma medicine?	☐	☐
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
28. Have you had infectious mononucleosis (mono) within the last month?	☐	☐
29. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
30. Have you had a herpes skin infection?	☐	☐
31. Have you ever had a head injury or concussion?	☐	☐
32. Have you been hit in the head and been confused or lost your memory?	☐	☐
33. Have you ever had a seizure?	☐	☐
34. Do you have headaches with exercise?	☐	☐
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
36. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
37. When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
39. Have you had any problems with your eyes or vision?	☐	☐
40. Do you wear glasses or contact lenses?	☐	☐
41. Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
42. Are you happy with your weight?	☐	☐
43. Are you trying to gain or lose weight?	☐	☐
44. Has anyone recommended you change your weight or eating habits?	☐	☐
45. Do you limit or carefully control what you eat?	☐	☐
46. Do you have any concerns that you would like to discuss with a doctor?	☐	☐
FEMALES ONLY		
47. Have you ever had a menstrual period?	☐	☐

48. How old were you when you had your first menstrual period? _____
49. How many periods have you had in the last 12 months?_____

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_____

I, the undersigned parent of the above-named student, a minor and student at Archbishop Mitty High School, hereby authorize any supervisor employed by Archbishop Mitty High School to consent to any examination, treatment, emergency surgery, anesthetic, and/ or hospital care which is deemed advisable by any physician licensed under the provisions of the Medical Practice Act. This consent is given pursuant to the provision of section 25.8 Civil Code of California, and shall be effective for one year from the signature date listed below. I also understand that this examination is primarily for sports participation and is not intended to replace the routine health care visits as recommended by the student's personal physician.

➔ **Parent Signature** _____ **Date:**_____

STUDENT NAME: **GRADE:**

ARCHBISHOP MITTY HIGH SCHOOL DEPARTMENT OF ATHLETICS

PHYSICAL EXAMINATION

(To be completed by a Medical Professional)

Height:_____	Weight: _____	Pulse:	Blood Pressure: _____/_____
Visual Acuity: R 20/_____ L 20/ _____ Corrected: Y / N		Pupils: Equal / Unequal (R > L or L > R)	

MUSCULOSKELETAL EXAM		NORMAL	ABNORMAL FINDINGS	INITIALS
Neck	Rom			
	Strength			
	Joint Stability			
Shoulders	Rom			
	Strength			
	Joint Stability			
Elbows	Rom			
	Strength			
	Joint Stability			
Forearms/Wrists	Rom			
	Strength			
	Joint Stability			
Hands/Fingers	Rom			
	Strength			
	Joint Stability			
Back	Rom			
	Strength			
	Joint Stability			
Hips/ Thighs	Rom			
	Strength			
	Joint Stability			
Knees	Rom			
	Strength			
	Joint Stability			
Lower Leg/Ankles	Rom			
	Strength			
	Joint Stability			
Feet/ Toes	Appearance			

MEDICAL SCREEN	NORMAL	ABNORMAL FINDINGS
Appearance		
Eyes, Ears, Nose, Throat		
Lungs		
Heart – Rhythm: Regular Irregular Murmur: No Yes		
Abdomen		
Skin		

ATHLETIC CLEARANCE:

☐ Cleared without restrictions
☐ Cleared with recommendations for further evaluation/treatment for: _____
☐ Participation limited to specific sport (**See comments below)
☐ No athletic participation (**See comments below)

** Comments/ Recommendations: _____

I hereby certify that I have, on this date, examined this student and that on the basis of this examination and the student's medical history as furnished to me, found no reason which would make it medically inadvisable for this student to compete in athletics, except for those indicated above.

Physician's Name (Print): _____

Physician's Signature: _____ Date: _____

Use space provided below for medical office address