PREPARTICIPATION PHYSICAL EVALUATION

** A CURRENT YEAR PHYSICAL IS ON OR AFTER APRIL 15 OF THE PREVIOUS SCHOOL YEAR **

Name: _____ School: _____

Date of Birth: _____ Phone number: _____

Sex: _____ Age: _____ Grade (current year): _____ Grade (next year): _____

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

Do you have any allergies? ☐Yes ☐No If yes, please identify specific allergy: ☐Medicines ☐Pollens ☐Food ☐Stinging Insects

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

GENERAL QUESTIONS	YES	NO
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	**YES**	**NO**
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 ever 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, ECG/EKG, echocardiogram)		
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?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**YES**	**NO**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your 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 your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**YES**	**NO**
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 a broken or fractured bone or dislocated joint?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, 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? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive devices?		
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?		

MEDICAL QUESTIONS	YES	NO
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever become ill while exercising in the heat?		
35. Do you get frequent muscle cramps when exercising?		
36. Do you or someone in your family have sickle cell trait or disease?		
37. Have you had any problems with your eyes or vision?		
38. Have you had any eye injuries?		
39. Do you wear glasses or contact lenses?		
40. Do you wear protective eyewear, such as goggles or a face shield?		
41. Do you worry about your weight?		
42. Are you trying to or has anyone recommended that you gain or lose weight?		
43. Are you on a special diet or do you avoid certain types of foods?		
44. Have you ever had an eating disorder?		
45. Do you have any concerns that you would like to discuss with a doctor?		
HEAD INJURY HISTORY	**YES**	**NO**
46. Have you ever had a head injury or concussion? If YES, how many & when? _____		
47. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
48. Do you have a history of seizure disorder?		
49. Do you have headaches with exercise?		
50. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
51. Have you ever been unable to move your arms or legs after being hit or falling?		
FEMALES ONLY	**YES**	**NO**
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here (attach additional pages if necessary):

_____

_____

_____

_____

_____

_____

_____

_____

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

Sign Here

Parent/Guardian Signature: _____ Date: _____

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Name: _____ Date of Birth: _____

EXAMINATION		
Height: _____ Weight: _____ ☐ Male ☐ Female		
BP: ___/___ (___/___) Pulse: _____ Vision: R 20/_____ L 20/_____ Currently Corrected: ☐Yes ☐No		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance: • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span greater than height, hyperlaxity, 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 - if the patient is symptomatic)		
Skin: HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional: Duck-walk, single-leg hop		

CLEARANCE FORM

☐ 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: _____

_____

_____

I certify that I have examined the above student and recommended him/her as being able to compete in supervised athletic activity as dictated by the clearance recommendations above. *Please use office stamp if available*

Signature of physician: _____ MD, DO, PA, or NP

Name of physician (print): _____ Exam Date: _____

Address: _____ Phone: _____

PREPARTICIPATION PHYSICAL EVALUATION

** A CURRENT YEAR PHYSICAL IS ON OR AFTER APRIL 15 OF THE PREVIOUS SCHOOL YEAR **

STUDENT PARTICIPATION & PARENT/GUARDIAN CONSENT & ASSUMPTION OF RISK:

Participation in interscholastic athletics requires an acceptance of risk of injury. These risks include but are not limited to: death, quadriplegia, paraplegia, internal injury, concussion or post-concussion syndrome and musculoskeletal injuries. Some of these injuries may result in medical treatment, surgery and/or permanent disability. I/We understand that coaches, athletic trainers, and physicians (including side-line team physicians) will use their professional judgment when performing appropriate medical treatment.

I/we assume; and that I/we agree to, and hereby, waive any and all claims, suits, losses, actions, or causes of action against the MHSAA, its members, officers, representatives, committee-members, employees, agents, attorneys, insurers, volunteers, and affiliates based on any injury to me, my child, or any person, whether because of inherent risk, accident, negligence, or otherwise, during or arising in any way from my/my child's participation in an MHSAA-sponsored sport.

I further consent for the disclosure of information otherwise protected by FERPA and HIPAA for the purpose of determining eligibility for interscholastic athletics to the MHSAA and school district. I am/we are expected to adhere firmly to all established athletic policies of my school district and the MHSAA.

By my/my child's signature below, I/we acknowledge that I/we have received concussion educational information that meets Michigan Department of Health and Human Services and MHSAA requirements. I/we have had the opportunity to ask questions and hereby recognize the risk of injury and give my consent for my son/daughter to participate in interscholastic athletics.

Parent/Guardian Signature: _____ **Date:** _____

Athlete Signature: _____ **Date:** _____

EMERGENCY INFORMATION & AUTHORIZATION TO TREAT

Student Name: _____ Current Grade: _____

Student Cell #: _____ Graduation Year: _____

Parent(s)/Legal Guardian(s) Name: _____

Address: _____

Mother/Guardian Name: _____ Father/Guardian Name: _____

Main Contact Phone: _____ Main Contact Phone: _____

Secondary Contact Phone #: _____ Secondary Contact Phone #: _____

EMERGENCY CONTACT (OTHER THAN PARENT(S)):

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Phone: _____ Phone: _____

INSURANCE INFORMATION

Family Insurance Company/Carrier: _____ Address: _____

Contact/Group Number: _____ Phone Number: _____

PLEASE INDICATE ANY MEDICAL INFORMATION BELOW:

(Allergies, bee sting allergies, known drug reactions, current prescribed medications, asthma, seizure disorders, heart condition, disease, etc.)

_____

_____

AUTHORIZATION OF TREATMENT:

I, _____ hereby give permission for my son/daughter, _____ to undergo medical treatment for an injury or illness he/she may sustain or acquire while engaged in athletics. I understand medical personnel, including athletic trainers and team physicians will perform only those procedures within their training, credentialing, and scope of professional practice, to prevent, care for, and rehabilitate injuries and illnesses. In the event more serious medical treatment/procedures are required and I cannot be contacted for my consent, I authorize any licensed medical practitioner to perform such treatments; procedures medically necessary to alleviate the problem.

Parent/Guardian Signature: _____ **Date:** _____