

Preparticipation Physical Evaluation

HISTORY FORM

Date of Exam _____

Name _____ Sex _____ Age _____ Date of birth _____

Grade _____ School _____ Sport(s) _____

Address _____ Phone _____

Personal Physician _____

In case of emergency, contact:

Name _____ Relationship _____ Phone (H) _____ Phone (W) _____

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? ☐ Yes ☐ No
2. Do you have an ongoing medical condition (like diabetes or asthma)? ☐ Yes ☐ No
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? ☐ Yes ☐ No
4. Do you have allergies to medicines, pollens, foods, or stinging insects? ☐ Yes ☐ No
5. Have you ever passed out or nearly passed out DURING exercise? ☐ Yes ☐ No
6. Have you ever passed out or nearly passed out AFTER exercise? ☐ Yes ☐ No
7. Have you ever had discomfort, pain, or pressure in your chest during exercise? ☐ Yes ☐ No
8. Does your heart race or skip beats during exercise? ☐ Yes ☐ No
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) ☐ Yes ☐ No
11. Has anyone in your family died for no apparent reason? ☐ Yes ☐ No
12. Does anyone in your family have a heart problem? ☐ Yes ☐ No
13. Has any family member or relative died of heart problems or of sudden death before age 50? ☐ Yes ☐ No
14. Does anyone in your family have Marfan syndrome? ☐ Yes ☐ No
15. Have you ever spent the night in a hospital? ☐ Yes ☐ No
16. Have you ever had surgery? ☐ Yes ☐ No

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: ☐ Yes ☐ No
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below: ☐ Yes ☐ No
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: ☐ Yes ☐ No

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? ☐ Yes ☐ No
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? ☐ Yes ☐ No
22. Do you regularly use a brace or assistive device? ☐ Yes ☐ No
23. Has a doctor ever told you that you have asthma or allergies? ☐ Yes ☐ No

Yes No

24. Do you cough, wheeze, or have difficulty breathing during or after exercise? ☐ Yes ☐ No
25. Is there anyone in your family who has asthma? ☐ Yes ☐ No
26. Have you ever used an inhaler or taken asthma medicine? ☐ Yes ☐ No
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? ☐ Yes ☐ No
28. Have you had infectious mononucleosis (mono) within the last month? ☐ Yes ☐ No
29. Do you have any rashes, pressure sores, or other skin problems? ☐ Yes ☐ No
30. Have you had a herpes skin infection? ☐ Yes ☐ No
31. Have you ever had a head injury or concussion? ☐ Yes ☐ No
32. Have you been hit in the head and been confused or lost your memory? ☐ Yes ☐ No
33. Have you ever had a seizure? ☐ Yes ☐ No
34. Do you have headaches with exercise? ☐ Yes ☐ No
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? ☐ Yes ☐ No
36. Have you ever been unable to move your arms or legs after being hit or falling? ☐ Yes ☐ No
37. When exercising in the heat, do you have severe muscle cramps or become ill? ☐ Yes ☐ No
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? ☐ Yes ☐ No
39. Have you had any problems with your eyes or vision? ☐ Yes ☐ No
40. Do you wear glasses or contact lenses? ☐ Yes ☐ No
41. Do you wear protective eyewear, such as goggles or a face shield? ☐ Yes ☐ No
42. Are you happy with your weight? ☐ Yes ☐ No
43. Are you trying to gain or lose weight? ☐ Yes ☐ No
44. Has anyone recommended you change your weight or eating habits? ☐ Yes ☐ No
45. Do you limit or carefully control what you eat? ☐ Yes ☐ No
46. Do you have any concerns that you would like to discuss with a doctor? ☐ Yes ☐ No

FEMALES ONLY

47. Have you ever had a menstrual period? ☐ Yes ☐ No
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 _____

Name _____ Date of Birth _____

Height _____ Weight _____ % Body Fat (optional) _____ Pulse _____ BP _____ / _____ (____ / _____, ____ / ____)

Vision R 20/____ L 20/____ Corrected: Y N Pupils: Equal _____ Unequal _____

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)+			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

*Multiple-examiner set-up only.

+Having a third party present is recommended for the genitourinary examination.

Notes: _____

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

Parental Consent

_____ has my consent to compete in all athletics at Bethel Baptist Schools (BBS).
Student's Name

I give permission for him/her to travel by bus or car to and from any BBS athletic game or practice. I further understand it is my responsibility to make arrangements for getting my student home from the school campus after any practice or athletic competition. In the event of an emergency or accident, I hereby authorize a representative of the school to make such arrangements as he considers necessary for my child to receive medical or hospital care, including the necessary transportation (i.e. ambulance). Under such circumstances, I authorize such care and treatment to be performed by any physician or surgeon. By signing below, we support the steroid policy of the school and agree that the student will not use androgenic/anabolic steroids without the written permission of a fully licensed physician, as recognized by the American Medical Association, to treat a medical condition.

Signature of student athlete

Date

Signature of parent/guardian

Date

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CLEARANCE FORM

Name _____ Sex _____ Age _____ Date of birth _____

- ☐ Cleared without restriction
☐ Cleared, with recommendations for further evaluation or treatment for: _____

☐ Not Cleared for ☐ All sports ☐ Certain sports: _____ Reason: _____
Recommendations: _____

EMERGENCY INFORMATION

Allergies _____

Other Information _____

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

Steroid Policy

School personnel, including coaches, will not sell, distribute, or promote to students performance-enhancing dietary supplements that promote muscle building.

Students participating in interscholastic athletics are prohibited from using steroids or any other performance-enhancing supplement. Use of steroids to increase strength or growth can cause serious health problems. Steroids can keep teenagers from growing to their full height; they can also cause heart disease, stroke, and damaged liver function. Men and women using steroids may develop fertility problems, personality changes, and acne. Men can also experience premature balding and development of breast tissue. These health hazards are in addition to the civil and criminal penalties for unauthorized sale, use, or exchange of anabolic steroids.

A student who is found to have violated the agreement or this policy will be restricted from participating in athletics and will be subject to disciplinary procedures including, but not limited to, suspension or expulsion.

signature of parent

signature of student-athlete

Parent Information

Insurance Name _____ Identification Number _____
(use student's ID if applicable)

Father's Name _____ Home Phone Number _____ Work or Cell Phone Number _____

Mother's Name _____ Home Phone Number _____ Work or Cell Phone Number _____

If unable to reach a parent please call:

Name _____ Home Phone Number _____ Work or Cell Phone Number _____

Name _____ Home Phone Number _____ Work or Cell Phone Number _____