

Preparticipation Physical Evaluation - Physical Form

Last Name _____ First Name _____ Middle Initial _____ Date of Birth _____

Examination			
Height:	Weight:		
BP: / (/)	Pulse:	Vision: R 20/ L 20/	Corrected Yes No

Medical	Normal	Abnormal Findings
Appearance: Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse (MVP), and aortic insufficiency)		
Eyes / Ears / Nose / Throat - Pupils equal / Hearing		
Lymph Nodes		
Heart - Murmurs (auscultation standing, auscultation supine, and +/- Valsalva maneuver)		
Lungs		
Abdomen		
Skin - Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant Staphylococcus aureus (MRSA), or tinea corporis		
Neurologic		
Musculoskeletal:		
- Neck		
- Back		
- Shoulders/Arm		
- Elbow/Forearm		
- Wrist/Hand/Fingers		
- Hip/Thighs		
- Knees		
- Leg/Ankles		
- Foot/Toes		
- Functional: Double-leg squat test, single leg squat test, and box drop or step drop test		

Consider electrocardiography (ECG), echocardiography, and referral to cardiologist for abnormal cardiac history or examination findings or a combination of these.

Preparticipation Physical Evaluation

☐ Medically eligible for all sports without restriction.
☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of: _____
☐ Medically eligible for certain sports: _____
☐ Not medically eligible pending further evaluation.
☐ Not medically eligible for any sports.
 Recommendations: _____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. If conditions arise after the athlete had been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete and parents or guardians.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____ MD, DO, NP, or PA

Preparticipation Physical Evaluation - History Form

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of Birth: _____ Sex: _____

Date of Examination: _____ Sport(s): _____

List past and current medical conditions: _____

Have you ever had surgery? If yes, list all past surgical procedures: _____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional): _____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects): _____

General Questions		Medical Questions	
Yes	No	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		16. Do you cough, wheeze, or have difficulty breathing during or after exercise?	
2. Has a provider ever denied or restricted your participation in sports for any reason?		17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?	
3. Do you have any ongoing medical issues or recent illness?		18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?	
Heart Health Questions About You		19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)?	
4. Have you ever passed out or nearly passed out DURING or AFTER exercise?		20. Have you ever had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?	
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		21. Have you ever had numbness, tingling, or weakness in your arms or leg, or been unable to move your arms or legs after being hit or falling?	
6. Does your heart ever race, flutter in your chest or skip beats (irregular beats) during exercise?		22. Have you ever become ill while exercising in the heat?	
7. Has a doctor ever told you that you have any heart problems?		23. Do you or someone in your family have sickle cell trait or disease?	
8. Has a doctor ever ordered a test for your heart? (for example Electrocardiography (ECG) or echocardiography.		24. Have you ever had or do you have any problems with your eyes or vision?	
9. Do you get lightheaded or feel shorter of breath than your friends during exercise?		25. Do you worry about your weight?	
10. Have you ever had a seizure?		26. Are you trying to or has anyone recommended that you gain or lose weight?	
Health Questions About Your Family		27. Are you on a special Diet or do you avoid certain types of foods?	
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 (including drowning or unexplained car accident)?		28. Have you ever had an eating disorder?	
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		Females Only	
13. Does anyone in your family had a pacemaker or implanted Defibrillator before age 35?		29. Have you ever had a menstrual period?	
None and Joint Questions		30. How old were you when you had your first menstrual period?	
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint or tendon that caused you to miss a game or practice?		31. When was your most recent menstrual period?	
15. Do you have a bone, muscle, ligament or joint injury that bothers you?		32. How many periods have you had in the past 12 months?	
		Explain a "Yes" answer here: _____	

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

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

CHESTER COUNTY SCHOOL DISTRICT

Concussion Acknowledgement and Signature Form for Parents and Student Athletes

Student Athlete's Name (Please Print) _____

Sports Participating in: _____ School Year: _____

Due to the new law "Student Athlete Concussions: Guidelines, Management" (R65, H3061), schools are now required to distribute information sheets to inform and educate student athletes and their parents of the nature and risk of concussion and head injury to student athletes, including the risks of continuing to play after a concussion or brain injury or returning to play too soon after a concussion or brain injury. The law requires that each year, before beginning practice for an interscholastic sport, including cheerleading, a high school student athlete and the student athlete's parents must be given an information sheet, and both must sign and return the form acknowledging receipt of the information to the athletic trainer. The law further states that a high school athlete who is suspected of sustaining a concussion or brain injury in a practice or game, shall be removed from play at the time of injury and may not return to play until the student athlete has received written medical clearance by a physician.

Parent and Student Athletes – please read the attached "Heads Up – Parent/Athlete Concussion Information Sheet." After reading this fact sheet, please sign below and ensure that your child also signs the form. Once signed, have your student athlete return this form to his/her coach or athletic trainer.

I, a student athlete participating in the above mentioned sport(s), I have received and read the "Heads Up – Parent/Athlete Concussion Information Sheet." I understand the nature and risk of concussion and brain injury to student athletes, including the risks of continuing to play after a concussion or brain injury. I agree to inform the coaches and athletic trainers of any concussive symptoms that I encounter. I also understand that after written medical clearance is given, I must be released by the athletic trainers after a return to play protocol has been followed.

Printed Student Athlete Name

Signature of Student Athlete

Date

I, as the parent or legal guardian of the above named student, have received and read the "Heads Up – Parent/Athlete Concussion Information Sheet." I understand the nature and risk of concussion and brain injury to student athletes, including the risks of continuing to play after concussion or brain injury. I will inform the coaches and athletic trainers of any concussive symptoms that I observe. I also understand that after written medical clearance is given, my child must be released by the athletic trainers after a return to play protocol has been followed.

Printed Parent Name

Signature of Parent

Date

Parent's Permission & Acknowledgement of Risk for Son or Daughter to Participate in Athletics

Name (please print) _____

As a parent or legal guardian of the above named student-athlete, I give permission for his/her participation in athletic events and the physical evaluation for that participation. I understand that this is simply a screening evaluation and not a substitute for regular health care. I also grant permission for treatment deemed necessary for a condition arising during participation of these events, including medical or surgical treatment that is recommended by a medical doctor. I grant permission to nurses, trainers and coaches as well as physicians or those under their direction who are part of athletic injury prevention and treatment, to have access to necessary medical information. I know that the risk of injury to my child/ward comes with participation in sports and during travel to and from play and practice. I have had the opportunity to understand the risk of injury during participation in sports through meetings, written information or by some other means. My signature indicates that to the best of my knowledge, my answers to the above questions are complete and correct. I understand that the data acquired during these evaluations may be used for research purposes.

Signature of Athlete _____

Date

Signature of Parent/Guardian _____

Date

CONSENT FORM

I plan to participate in the following athletic activity: _____

I understand that my participation in athletics and the reputation of my school are dependent on my conduct as an individual. I hereby agree to accept and abide by the standards, rules, and regulations set forth by the Chester County School District Board of Trustees.

I authorize Chester County School District to test my urine for drugs and alcohol, pursuant to board policy and the accompanying administrative rule. If my name is selected from a random pool, I also authorize the release of the test results to district personnel needed to execute the random drug and alcohol testing program.

Student's Name

Student's ID Number

Student's Signature

Date

Parent/Legal Guardian Name

Parent/Legal Guardian Telephone No.

Parent/Legal Guardian Signature

Date

Student Athlete Contract

Signing this page indicates that I have read and understand
the Chester County School District Athletic Handbook.

School

Print Player's Name

Player's Signature

Parent's Signature

