

**Pre-Participation History and Physical Examination** (rev. 12/2010)

Name (print full name) \_\_\_\_\_ Birth Date \_\_\_\_\_ Pupil # \_\_\_\_\_ Exam Date \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Sport \_\_\_\_\_ Grade \_\_\_\_\_ M  F

*Parents/Guardians must complete the reverse side before physical appointment.*

MEDICAL AUTHORITIES LICENSED TO GIVE PHYSICAL EXAMINATIONS		
<input type="checkbox"/> Medical Doctor (MD)	<input type="checkbox"/> Certified Nurse Practitioner (CRN)	<input type="checkbox"/> Naturopaths (ND)
<input type="checkbox"/> Doctor of Osteopathy (DO)	<input type="checkbox"/> Medics-Physician Assistant (PA)	

Age \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_ ↓ This Section Optional ↓  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ Urinalysis \_\_\_\_\_  
 Visual Acuity: Left: 20/ \_\_\_\_\_ Right: 20/ \_\_\_\_\_ Body Fat% \_\_\_\_\_  
HCT \_\_\_\_\_

**Normal**

- Head
- Eyes (pupils), ENT
- Teeth
- Chest
- Lungs
- Heart
- Abdomen
- Genitalia
- Neurological
- Skin
- Physical Maturity
- Spine, Back
- Shoulders, Upper extremities
- Lower extremities

**Abnormal**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Assessment**

- Full participation
- Limited participation (describe limitations, restrictions) \_\_\_\_\_
- Life threatening condition (severe asthma, bee/food allergy) requires medication order before participation. (Please attach the information/medication orders.)**

Participation contradicted (list reasons) \_\_\_\_\_

**Recommendations** (equipment, taping, rehabilitation, etc.)

**Examiner's Certification**

**Authorized examiners are medical authorities licensed to give medical examinations. (WIAA 18.13.1)**

I hereby certify that the above-named individual is physically qualified to participate in all interscholastic athletic activities NOT CROSSED OUT BELOW:

Baseball	Basketball	Bowling	Cheerleading	Cross Country	Drill Team	Football	Golf
Gymnastics	Soccer	Softball	Swimming	Tennis	Volleyball	Wrestling	Track

**Wrestling Weight Permit:** Circle lowest weight classifications permissible

Senior High	103	112	119	125	130	135	140	145	152	161	171	189	215	275
Junior High	75	80	85	90	95	100	105	110	115	120	125	130	135	140
							152	162	172	185	Unlimited (must be over 185)			

Examiner's Name (print) \_\_\_\_\_ Examiner's Phone (\_\_\_\_) \_\_\_\_\_  
 Examiner's Signature \_\_\_\_\_ Date \_\_\_\_\_

## Pre-Participation History

Yes No

- Have you had any illness/injury recently, or do you have an illness/injury now?
- Have you had a medical problem, illness, or injury since your last exam?
- Do you have any chronic or recurrent illness?
- Have you ever had any illness lasting more than a week?
- Have you ever been hospitalized overnight?
- Have you had any surgery other than tonsillectomy?
- Have you ever had any injuries requiring treatment by a physician?
- Do you have any organ missing other than tonsils (appendix, eye, kidney, testicle, etc.)?
- Are you presently taking ANY medications (including birth control pills, vitamins, aspirin, etc.)?
- Do you have ANY allergies (medicines, bees, foods, or other factors)?
- Have you ever had chest pain, dizziness, faintness, passing out during or after exercise?
- Do you tire more easily or quickly than your friends during exercises?
- Have you ever had any problem with your blood pressure or your heart?
- Have any close relatives had heart problems, heart attack, or sudden death before they were age 50?
- Do you have any skin problems (acne, itching, rashes, etc.)?
- Have you ever had fainting, convulsions, seizures, or severe dizziness?
- Do you have frequent severe headaches?
- Have you ever had a "stinger" or "burner" or "pinched nerve"?
- Have you ever been "knocked out" or "passed out"?
- Have you ever had a neck or head injury?
- Have you ever had heat exhaustion, heat stroke, heat cramps, or similar heat-related problems?
- Have you had asthma, or trouble breathing, or cough during or after exercise?
- Do you wear eyeglasses, contact lenses, or protective eye wear?
- Have you had any problems with your eyes or vision?
- Do you wear any dental appliances such as braces, bridge, plate, retainer?
- Have you ever had a knee injury?
- Have you ever had an ankle injury?
- Have you ever injured any other joint (shoulder, wrist, fingers, etc.)?
- Have you ever had a broken bone (fracture)?
- Have you ever had a cast, splint, or had to use crutches?
- Must you use special equipment for competition (pads, braces, neck roll, etc.)?
- Has it been more than 5 years since your last tetanus booster shot?
- Are you worried about your weight?
- FEMALES: Have you any menstrual problems?
- Have you any medical concerns about participating in your sport?

Recommendations

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