Santa Margarita Catholic High School

2019-2020 Pre-Participation Physical Evaluation

Name_____ Sex_____ Age_____ Date of Birth_____

Grade 2019-20_____ School_____ Sports _____

Address _____ Phone _____

Personal Physician_____

In case of emergency, ***contact***

Name_____ Relation_____ Phone (H)_____ Cell_____

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

	Yes	No
1. Have you had a medical illness or injury since your last checkup or physical?	□	□
2. Have you ever been hospitalized overnight?	□	□
Have you ever had surgery?	□	□
3. Are currently taking any prescription or nonprescription (over the counter medications) or pills or using an inhaler?	□	□
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve you performance?	□	□
4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	□	□
Have ever had a rash or hives develop during or after exercise?	□	□
5. Have you ever passed out during or after exercise?	□	□
Have you ever been dizzy during or after exercise?	□	□
Have you ever had chest pain during or after exercise?	□	□
Do you get tired more quickly than your friends do during exercise?	□	□
Have ever had racing of your heart or skipped heartbeats?	□	□
Have you had high blood pressure or high cholesterol?	□	□
Have you ever been told you have a heart murmur?	□	□
Has any family member died of heart problems or of sudden death before age 50?	□	□
Have you had severe viral infection (for example, myocarditis or mononucleosis) within the last month?	□	□
Has a physician ever denied or restricted your participation in sports for any heart problems?	□	□
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	□	□
7. Have you ever had a head injury or concussion?	□	□
Have you ever been knocked out, become unconscious, or lost your memory?	□	□
Have you ever had a seizure?	□	□
Do you have frequent or severe headaches?	□	□
Have you ever had numbness or tingling in your arms, hands, legs, or feet?	□	□
Have you ever had a stinger, burn, or pinched nerve?	□	□
8. Have you ever become ill from exercising in the heat?	□	□
9. Do you cough, wheeze, or have trouble breathing during or after activity?	□	□
Do you have asthma?	□	□
Do you have seasonal allergies that require medical treatment?	□	□

	Yes	No
10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, or hearing aid?	□	□
11. Have you had any problems with your eyes or vision?	□	□
Do you wear glasses, contacts, or protective eyewear?	□	□
12. Have you ever had a sprain, strain, or swelling after injury?	□	□
Have you broken or fractured any bones or dislocated any joints?		
Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	□	□

If yes, check appropriate box and explain below.

□ Head	□ Elbow	□ Hip
□ Neck	□ Forearm	□ Thigh
□ Back	□ Wrist	□ Knee
□ Chest	□ Hand	□ Shin/Calf
□ Shoulder	□ Finger	□ Ankle
□ Upper Arm		□ Foot

13. Do you want to weigh more or less than you do now?	□	□
Do you lose weight regularly to meet weight requirements for your sport?	□	□
14. Do you feel stressed out?	□	□

15. Record the date of your most recent immunizations:

Tetanus_____ Measles_____

Hepatitis B_____ Chickenpox_____

FEMALES ONLY

16. When was your first menstrual period?_____

When was your most recent menstrual period?_____

How much time do you usually have from the start of one period to the start of another?_____

How many periods have you had in the last year?_____

What was the longest time between in the last year?_____

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 _____

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Name_____ Date of Birth_____

Height_____ Weight_____ % Body Fat (optional)_____ Pulse_____ BP____/____ (____/____, ____/____)

Vision R 20/ L20/ Corrected: Y N Pupils: Equal Unequal

	NORMAL	ABNORMAL FINDINGS	INITIALS
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (Males Only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*Station based examination only

CLEARANCE

☐ Cleared

☐ Cleared after completing evaluation/rehabilitation for: _____

_____

_____

_____

Not cleared for:_____ Reason:_____

Recommendations:_____

_____

_____

_____

Name of Physician (Print/Type)_____ Date _____

Address _____ Phone _____

Signature of Physician _____ MD or DO