Preparticipation Physical Evaluation
HISTORY FORM
(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam ____________________________  Date of birth __________________________

Name __________________________________________________________________________________

Sex  _______  Age  __________  Grade  _____________  School  _____________________________  Sport(s)  __________________________________

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

__________________________________________________________

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

Explain “Yes” answers below. Circle questions you don’t know the answers to.

GENERAL QUESTIONS

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

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
   ☐ 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 than your friends during exercise?

HEART HEALTH QUESTIONS ABOUT YOUR FAMILY

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

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 any broken or fractured bones or dislocated joints?
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, orthotic, or other assistive device?
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

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), your 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 had a head injury or concussion?
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?
36. Do you have a history of seizure disorder?
37. Do you have headaches with exercise?
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?
39. Have you ever been unable to move your arms or legs after being hit or falling?
40. Have you ever become ill while exercising in the heat?
41. Do you get frequent muscle cramps when exercising?
42. Do you or someone in your family have sickle cell trait or disease?
43. Have you had any problems with your eyes or vision?
44. Have you had any eye injuries?
45. Do you wear glasses or contact lenses?
46. Do you wear protective eyewear, such as goggles or a face shield?
47. Do you worry about your weight?
48. Are you trying to or has anyone recommended that you gain or lose weight?
49. Are you on a special diet or do you avoid certain types of foods?
50. Have you ever had an eating disorder?
51. Do you have any concerns that you would like to discuss with a doctor?

FEMALES ONLY

52. Have you ever had a menstrual period?
53. Have you ever had an eating disorder?
54. 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 _____________________

**Preparticipation Physical Evaluation**

**THE ATHLETE WITH SPECIAL NEEDS:**

**SUPPLEMENTAL HISTORY FORM**

Date of Exam ___________________________________________________________________________________________________________________

Name __________________________________________________________________________________ Date of birth __________________________

Sex _______ Age __________ Grade _____________ School _____________________________ Sport(s) __________________________________

1. Type of disability

2. Date of disability

3. Classification (if available)

4. Cause of disability (birth, disease, accident/trauma, other)

5. List the sports you are interested in playing

<table>
<thead>
<tr>
<th>6. Do you regularly use a brace, assistive device, or prosthetic?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Do you use any special brace or assistive device for sports?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>8. Do you have any rashes, pressure sores, or any other skin problems?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>9. Do you have a hearing loss? Do you use a hearing aid?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>10. Do you have a visual impairment?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>11. Do you use any special devices for bowel or bladder function?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>12. Do you have burning or discomfort when urinating?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>13. Have you had autonomic dysreflexia?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>15. Do you have muscle spasticity?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>16. Do you have frequent seizures that cannot be controlled by medication?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Explain “yes” answers here

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Please indicate if you have ever had any of the following.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atlantoaxial instability</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>X-ray evaluation for atlantoaxial instability</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Dislocated joints (more than one)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Easy bleeding</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Enlarged spleen</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Hepatitis</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Osteopenia or osteoporosis</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Difficulty controlling bowel</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Difficulty controlling bladder</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Numbness or tingling in arms or hands</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Numbness or tingling in legs or feet</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Weakness in arms or hands</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Weakness in legs or feet</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Recent change in coordination</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Recent change in ability to walk</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Spina bifida</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Latex allergy</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Explain “yes” answers here

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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 _____________________

Preparticipation Physical Evaluation

PHYSICAL EXAMINATION FORM

Name ___________________________________________ Date of birth __________________________

PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues
   • Do you feel stressed out or under a lot of pressure?
   • Do you ever feel sad, hopeless, depressed, or anxious?
   • Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   • During the past 30 days, did you use chewing tobacco, snuff, or dip?
   • Do you drink alcohol or use any other drugs?
   • Have you ever taken anabolic steroids or used any other performance supplement?
   • Do you wear a seat belt, use a helmet, and use condoms?

2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION

Height

<table>
<thead>
<tr>
<th>BP</th>
<th>Weight</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

Male

Female

PHYSICAL FINDINGS

MEDICAL

Normal

Abnormal Findings

Appearance

Eyes/ears/nose/throat

Lymph nodes

Heart

Pulses

Lungs

Abdomen

Genitourinary (males only)

Skin

Neurologic

MUSCULOSKELETAL

Neck

Back

Shoulder/arm

Elbow/forearm

Wrist/hand/fingers

Hip/thigh

Knee

Leg/ankle

Foot/toes

Functional

Duck-walk, single leg hop

*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

†Consider GU exam if in private setting. Having third party present is recommended.

‡Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

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 have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) ___________________________________________ Date ____________

Address ___________________________________________ Phone __________________________

Signature of physician _______________________________________________, MD or DO

WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION – ATHLETIC PERMIT CARD

Physical examination taken April 1 and thereafter is valid for the following two school years; physical examination taken before April 1 is valid only for the remainder of that school year and the following school year.

NAME (Last) __________________________ (First) __________________________ (Middle Initial) __________ Date of Birth __________
Age ______ Sex ______ Grade ______ School __________________________ City __________________________

Present Address __________________________ Telephone __________________________

☐ Cleared without restriction  ☐ Cleared, with the following qualifications:

☐ Not cleared  ☐ Pending further evaluation  ☐ For all sports  ☐ For certain sports:

Reason: __________________________________________________________________________________________________________

Recommendations:

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of Physician (Print/Type) ____________________________________________________________

SIGNATURE OF LICENSED PHYSICIAN (MD OR DO)/APNP*: __________________________

Clinic Name __________________________

Address/Clinic __________________________ City __________________________ State ______ Zip Code ______

Telephone __________________________ Date of Examination __________

* Physicians may authorize Nurse Practitioners or Physician Assistants to stamp this card with the physician’s signature or the name of the clinic with which the physician is affiliated.

Parents’ Place of Employment __________________________

Family Physician __________________________ Family Dentist __________________________

Name of Private Insurance Carrier __________________________ Telephone __________________________

Subscriber Member Name (Primary Insured) __________________________

Emergency Information

Allergies __________________________________________________________________________________________

Other Information (medication, etc.) ____________________________________________________________________________________

Immunizations  ☐ Up to date (see attached documentation)  ☐ Not up to date - specify
(e.g., tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; poliomyelitis; pneumococcal; meningococcal; varicella)

1. I hereby give my permission for the above named student to practice and compete and represent the school in WIAA approved interscholastic sports except those restricted on this card.

2. Pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder (collectively known as “HIPAA”), I authorize health care providers of the student named above, including emergency medical personnel and other similarly trained professionals that may be attending an interscholastic event or practice, to disclose/exchange essential medical information regarding the injury and treatment of this student to appropriate school district personnel such as but not limited to: Principal, Athletic Director, Athletic Trainer, Team Physician, Team Coach, Administrative Assistant to the Athletic Director and/or other professional health care providers, for purposes of treatment, emergency care and injury record-keeping.

SIGNATURE OF PARENT/GUARDIAN __________________________ DATE __________