

BISHOP SNYDER HIGH SCHOOL PRE-PARTICIPATION PHYSICAL EVALUATION

Part 1 Student Information (to be completed by student or parent)

Student's name: _____ Sex: _____ Age: _____ Date of Birth: ____/____/____

Home Address: _____ Home Phone: (____) _____

Work Phone (____) _____ Cell Phone (____) _____ Pager (____) _____

Name of Parent/Guardian: _____

Person to Contact in Case of Emergency: _____

Relationship to Student: _____ Home Phone: (____) _____ Work Phone: (____) _____

Family Physician: _____ City/State: _____ Office Phone: (____) _____

Part 2 Medical History - Explain "yes" answers below. Circle questions you don't know answer to.

	YES	NO
1) Date of last full physical exam: ____/____/____ (previous to today's date)	_____	_____
2) Have you had a medical illness or injury since your last check up or sports physical?	_____	_____
3) Do you or anyone in your family have/ had:		
a. heart/vessel disease?	_____	_____
b. kidney/ liver problems?	_____	_____
c. strokes or CVA's?	_____	_____
d. diabetes?	_____	_____
e. epilepsy?	_____	_____
4) Are you currently taking any prescription or nonprescription medications or pills or using an inhaler?	_____	_____
5) Do you have or have you ever had		
a. an ongoing illness?	_____	_____
b. overnight hospitalization?	_____	_____
c. surgery?	_____	_____
d. any allergies?	_____	_____
e. a heart murmur?	_____	_____
f. a severe viral infection?	_____	_____
g. any current skin problems?	_____	_____
h. a seizure?	_____	_____
i. frequent or severe headaches?	_____	_____
j. asthma?	_____	_____
k. problems with eyes or vision?	_____	_____
l. racing of your heart or skipped heart beats?	_____	_____
m. high blood pressure or high cholesterol?	_____	_____
n. a head injury, concussion, lost consciousness, or lost your memory?	_____	_____
o. numbness or tingling in your arms, hands, legs or feet?	_____	_____
p. a stinger, burner, or pinched nerve?	_____	_____
q. difficulty with exercising in the heat?	_____	_____
r. a sprain, strain, or swelling after injury?	_____	_____
s. any broken or fractured bones or dislocated joints?	_____	_____
t. any other problems with pain or swelling in muscles, bones, tendons, or joints?	_____	_____
6) During or after exercise, do you or have you ever:		
a. been dizzy or passed out?	_____	_____
b. had chest pain?	_____	_____
c. cough, wheeze, or have trouble breathing?	_____	_____
d. tire more quickly than your friends do?	_____	_____
7) Has a physician ever denied or restricted your participation in sports for any heart problems?	_____	_____
8) Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (i.e. knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	_____	_____
9) Do you have any unusual reactions to heat or cold?	_____	_____
10) Do you lose weight regularly to meet weight requirements for your sport?	_____	_____
MALES ONLY		
11) Have you had testicular surgery or only have one testicle	_____	_____

Explain "yes" answers here. (Please place # from above first, and then explain):

Signature of Student _____	Date: _____
Signature of Parent/Guardian _____	Date: _____

Physical evaluation reviewed by physician Physician signature _____ Date: _____

2008 – 2009

BISHOP JOHN SNYDER HIGH SCHOOL PHYSICAL EXAM

(Physicals must be dated after May 25, 2008 and are valid through the following school year.)

Student Name _____

Height (inches)	_____	HEENT	WNL	ABN
Weight (pounds)	_____	Neck	_____	_____
Blood pressure	_____	Lungs	_____	_____
Pulse	_____	Heart	_____	_____
Vision		Abdomen	_____	_____
Right eye	20/_____	Genitals	_____	_____
Left eye	20/_____	Skin	_____	_____
Contacts/glasses	Yes No	Appearance	_____	_____
Pupils	Equal Unequal			

	WNL	ABN		WNL	ABN
Neck	_____	_____	Knee	_____	_____
Spine	_____	_____	MCL	_____	_____
Shoulder	_____	_____	LCL	_____	_____
Stability	_____	_____	ACL	_____	_____
Alignment	_____	_____	PCL	_____	_____
Elbow/Forearm	_____	_____	Meniscus	_____	_____
Wrist Hand	_____	_____	Patella	_____	_____
Hip/Thigh	_____	_____	Pain	_____	_____
Ankle	_____	_____	Apprehension	_____	_____
Stability	_____	_____	Crepitation	_____	_____
Alignment	_____	_____	Functional Test	_____	_____
Feet	_____	_____	One Leg Hop	_____	_____
			Full Squats	_____	_____

Cleared for Participation YES _____ NO _____

COMMENTS:

Physician's Signature _____ Date _____