PART II- MEDICAL HISTORY (Explain "YES" answers below) Name: _____Grade: _____

This form must be completed and signed, prior to the physical examination, for review by examining practitioner.
Explain "YES" answers below with number of the question. Circle questions you don't know the answers to.

GENERAL MEDICAL HISTORY	YES	NO
1. Do you have any concerns you want to discuss with your provider?	☐	☐
2. Has a provider ever denied or restricted your participation in sports for any reason?	☐	☐
3. Do you have any ongoing medical conditions? If so, please identify: ☐ Asthma ☐Anemia ☐Diabetes ☐ Infections. ☐Other: _____	☐	☐
4. Are you taking any medications or supplements daily?	☐	☐
5. Do you have allergies to any medications?	☐	☐
6. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?	☐	☐
7. Have you ever spent the night in the hospital? If yes, why? _____	☐	☐
8. Have you ever had surgery?	☐	☐
HEART HEALTH QUESTIONS ABOUT YOU	**YES**	**NO**
9. Have you ever passed out or nearly passed out DURING or AFTER exercise?	☐	☐
10. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	☐	☐
11. Does your heart race, flutter in your chest or skip beats (irregular beats) during exercise?	☐	☐
12. Has a doctor ever ordered a test for your heart? For example, electrocardiography or echocardiography.	☐	☐
13. Has a doctor ever told you that you have any heart problems, including: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki Disease ☐ Other _____	☐	☐
14. Do you get light-headed or feel shorter of breath than your friends during exercise?	☐	☐
15. Have you ever had a seizure?	☐	☐
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**YES**	**NO**
16. Does anyone in your family have a heart problem?	☐	☐
17. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning or unexplained car crash)?	☐	☐
18. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?	☐	☐
19. Has anyone in your family had a pacemaker or an implanted defibrillator before age 50?	☐	☐
BONE AND JOINT QUESTIONS	**YES**	**NO**
20. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?	☐	☐
21. Do you currently have a bone, muscle, or joint injury that bothers you?	☐	☐
MEDICAL QUESTIONS	**YES**	**NO**
22. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
23. Do you have asthma or use asthma medicine (inhaler, nebulizer)?	☐	☐

MEDICAL QUESTIONS CONTINUED	YES	NO
24. Have you had mononucleosis (mono) within the last month?	☐	☐
25. Are you missing a kidney, eye, testicle, spleen or other internal organ?	☐	☐
26. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?	☐	☐
27. Have you ever become ill while exercising in the heat?	☐	☐
28. When exercising in the heat, do you have severe muscle cramps?	☐	☐
29. Do you have headaches from exercise?	☐	☐
30. Have you ever had numbness, tingling or weakness in your arms or legs or been unable to move your arms or legs AFTER being hit or falling?	☐	☐
31. Do you have sickle cell trait or disease? Does someone in your family have sickle cell trait or disease?	☐ ☐	☐ ☐
32. Have you had any other blood disorders?	☐	☐
33. Have you had a concussion or head injury that caused confusion, a prolonged headache or memory problems?	☐	☐
34. Have you had or do you have any problems with your eyes or vision?	☐	☐
35. Do you wear glasses or contacts?	☐	☐
36. Do you wear protective eyewear like goggles or a face shield?	☐	☐
37. Do you worry about your weight?	☐	☐
38. Have you ever been diagnosed with an eating disorder?	☐	☐
39. Are you on a special diet or do you avoid certain types of foods or food groups?	☐	☐
4 0 . Allergies to food or stinging insects?	☐	☐
41. Have you ever had a COVID-19 diagnosis? Date:		
42. What is the date of your last Tdap or Td (tetanus) immunization? (circle type) Date: _____		

FEMALES ONLY	YES	NO
45. Have you ever had a menstrual period?	☐	☐

46. Age when you had your first menstrual period: _____

47. Number of periods in the last 12 months: _____

48. When was your most recent menstrual period? _____

EXPLAIN "YES" ANSWERS BELOW list the number you are clarifying/explaining

-
-
-
-
-
-
-

List medications and nutritional supplements you are currently taking here:

→ Parent/Guardian Signature: _____ Date: _____ → Athlete's Signature: _____

PART III- PHYSICAL EXAMINATION
(Pre-participation Physical may not be completed/signed by a parent/guardian even if a licensed healthcare professional)

NAME_____ **DATE OF BIRTH**_____**SCHOOL**_____

Height		Weight		Sex Assigned at Birth	
BP /	RR	Resting pulse	Vision R 20/	L 20/	Corrected ☐ Yes ☐ No
Pediatric Population > 13 years and older within normal limits =			**BP (F) 102-121/64-79 mmHg**		**BP (M) 102-124/64-80 mmHg**
			RR 12-20 breaths per minute		**Pulse 55-90 bpm**

MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance (Marfan stigmata: kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse, and aortic insufficiency)		
Eyes/ears/nose/throat (Pupils equal, hearing)		
Neck - Lymph nodes, thyroid enlargement		
Heart (Murmurs: auscultation standing, supine, +/- Valsalva)		
Pulses (radial, femoral, pedal)		
Lungs		
Abdomen		
Skin (Herpes simplex virus, lesions suggestive of MRSA or tinea corporis)		
Neurologic (cranial nerve and gait)		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional (i.e. Double leg squat, single leg squat, box drop, or step drop test)		

Consider ECG, Echocardiogram, and referral to cardiology if abnormal cardiac history/exam or family history to address Sudden Cardiac Arrest & Sudden Cardiac Death risk.
Consider cognitive evaluation or baseline neuropsychiatric testing if history of significant prior to concussion.

Emergency medications required on-site: ☐ Inhaler ☐ Epinephrine ☐ Glucagon ☐ Other:

COMMENTS:

I have reviewed the data above, reviewed the student's medical history form and make the following commendations for the students' participation in athletics:

☐ **Healthcare Professional completed and reviewed a Mental Health Screening with the athlete.**

☐ **MEDICALLY ELIGIBLE FOR ALL SPORTS WITHOUT RESTRICTION**
☐ **MEDICALLY ELIGIBLE FOR ALL SPORTS WITHOUT RESTRICTION WITH RECOMMENDATION FOR FURTHER EVALUATION OR TREATMENT OF:**

_____

☐ **MEDICALLY ELIGIBLE ONLY FOR THE FOLLOWING SPORTS:**_____
Reason:_____
☐ **NOT MEDICALLY ELIGIBLE FOR ANY SPORTS**

By this signature, I attest that I have examined the above student and completed this pre-participation physical including a review of Medical History.

→ **PRACTITIONER SIGNATURE:** _____**(MD, DO, NP or PA) + DATE**:** _____

EXAMINER'S NAME AND DEGREE (PRINT): _____ PHONE NUMBER: _____

ADDRESS: _____CITY: _____STATE: _____ZIP: _____

Physician Office Stamp:

+Only signature of Doctor of Medicine, Doctor of Osteopathic Medicine, Nurse Practitioner or Physician's Assistant licensed to practice in the United States will be accepted.