

MEDICAL ELIGIBILITY FORM



PREPARTICIPATION PHYSICAL EVALUATION

Date of birth: Name: ☐ Medically eligible for all sports without restriction Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of ☐ Medically eligible for certain sports ☐ Not medically eligible pending further evaluation □ Not medically eligible for any sports Recommendations: I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are 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, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians). Address: _____ ______ Phone: _____ Signature of health care professional: _______, MD, DO, NP, or PA SHARED EMERGENCY INFORMATION Medications: Other information: Emergency contacts:

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PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment. Name: Date of birth:						
Pate of examination:	Sport(s):					
ex assigned at birth (F, M, or intersex):	How do	How do you identify your gender? (F, M, or other):				
List past and current medical conditions.				***************************************		
Have you ever had surgery? If yes, list all past surgi	cal procedures.					
Medicines and supplements: List all current prescri	otions, over-the-co	unter medicines, a	nd supplements (herbal	and nutritional).		
Do you have any allergies? If yes, please list all yo	ur allergies (ie, me	dicines, pollens, fo	ood, stinging insects).			
Patient Health Questionnaire Version 4 (PHQ-4)	othered by any of	the following prob)		
Patient Health Questionnaire Version 4 (PHQ-4)	othered by any of	the following prob	lems? (Circle response.,)		
Patient Health Questionnaire Version 4 (PHQ-4) Over the last 2 weeks, how often have you been b	othered by any of Not at all	the following prob	lems? (Circle response. Over half the days) Nearly every da		
Patient Health Questionnaire Version 4 (PHQ-4) Over the last 2 weeks, how often have you been b Feeling nervous, anxious, or on edge	othered by any of Not at all 0	the following prob	lems? (Circle response. Over half the days) Nearly every do 3		

Exp	ERAL QUESTIONS lain "Yes" answers at the end of this form. e questions if you don't know the answer.)	Yes	No.
.	Do you have any concerns that you would like 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 issues or recent illness?		
HEA	RT HEALTH QUESTIONS ABOUT YOU	Yes	No
4.	Have you ever passed out or nearly passed out during or after exercise?		
5.	Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6.	Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7.	Has a doctor ever told you that you have any heart problems?		
8.	Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
12. 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 poly- morphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

111165116	JE AND JOINT QUESTIONS	Yes	No	Mai	DICAL QUESTIONS (CONTINUED)	Yes	No
4.	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?			ļ	Do you worry about your weight? Are you trying to or has anyone recommended		
5.	Do you have a bone, muscle, ligament, or joint injury that bothers you?			27.	that you gain or lose weight? Are you on a special diet or do you avoid certain types of foods or food groups?		
	OICAL QUESTIONS	Yes	No	28.	Have you ever had an eating disorder?	1	
,	Do you cough, wheeze, or have difficulty breathing during or after exercise?			2000	ALES ONLY	Yes	No
	Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?				How old were you when you had your first menstrual period?		<u> </u>
	Do you have groin or testicle pain or a painful bulge or hernia in the groin area?			31.	When was your most recent menstrual period?	1	
) <u>,</u>	Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?			<u></u>	How many periods have you had in the past 12 months? sin "Yes" answers here.		
	Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?						
•	Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or			***************************************			
	falling?						

	falling? Have you ever become ill while exercising in the						

No

No

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Signature of parent or guardian:

Date:



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Signature of health care professional:



,, MD, DO, NP, or PA

PREPARTICIPATION PHYSICAL EVALUATION

			-			
Name:	aanamummaanan maanamaa maana maa		L	Date of birth:		
PHYSICIAN	REMINDERS					
	er additional questions on mo					
	ou feel stressed out or under					
	ou ever feel sad, hopeless, c					
• Do)	ou feel safe at your home or	residence?				
•						
		use chewing tobacco, snuff, or dip?	2			
	ou drink alcohol or use any	other drugs?				
		eroids or used any other performance				
		eroids or used any other performance ments to help you gain or lose weight				
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• Hav • Do y 2. Consider EXAMINATE Height: BP: /	e you ever taken any suppler you wear a seat belt, use a hi er reviewing questions on car ION Weight (/) Pulse	ments to help you gain or lose weight elmet, and use condoms? rdiovascular symptoms (Q4–Q13 of h	t or improve your per History Form).	formance? Corrected:	NYZÁRHTZINNIÁRRANNÁÁRRAFARTA BIRNY	
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Have Doy 2. Consider EXAMINATHEIGHT: BP: / MEDICAL Appearance Marfan myopia,	e you ever taken any suppler you wear a seat belt, use a h er reviewing questions on car ION Weight (/) Pulse estigmata (kyphoscoliosis, hig mitral valve prolapse [MVP]	ments to help you gain or lose weight elmet, and use condoms? rdiovascular symptoms (Q4-Q13 of her) t: e: Vision: R 20/	t or improve your per History Form). L 20/	formance? Corrected:	NYZÁRHTZINNIÁRRANNÁÁRRAFARTA BIRNY	
Have Doy 2. Consider EXAMINATHEIGHT: BP: / MEDICAL Appearance Marfan myopia,	e you ever taken any suppler you wear a seat belt, use a hier reviewing questions on car ION Weight (/) Pulse estigmata (kyphoscoliasis, hig mitral valve prolapse [MVP] nose, and throat	ments to help you gain or lose weight elmet, and use condoms? rdiovascular symptoms (Q4-Q13 of her) t: e: Vision: R 20/	t or improve your per History Form). L 20/	formance? Corrected:	NYZÁRHTZINNIÁRRANNÁÁRRAFARTA BIRNY	

Heart ^o		
Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin		
 Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant Staphylococcus aureus (MRSA), or 		
tinea corporis		
Neurological		
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional		
Double-leg squat test, single-leg squat test, and box drop or step drop test		
Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac histo	ry or examin	ation findings, or a combi-
nation of those.	•	•
Name of health care professional (print or type):	Dat	e:
Address:	one:	

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