ERNEST RIGHETTI HIGH SCHOOL
Preparticipation Physical Evaluation

Demographic Information

Student's Name_____ Date of Birth_____ Sex_____ Grade_____

Student ID #_____ Sport(s) _____

Address_____

Parent/Guardian Name_____ Phone_____

Family Health History

*Explain "Yes" answers below. Circle questions if you do not know the answer.

	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2. Do you have an ongoing medical condition?	☐	☐
3. Are you currently taking any medicines?	☐	☐
4. Do you have allergies to medicine, foods, etc?	☐	☐
5. Have you ever passed out or nearly passed out DURING exercise?	☐	☐
6. Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
7. Have you ever had discomfort, pain or pressure in your chest during exercise?	☐	☐
8. Does your heart race or skip beats during exercise?	☐	☐
9. Has a doctor ever told you that you have: ☐High Blood Pressure ☐High Cholesterol ☐A Heart Murmur ☐A Heart Infection	☐	☐
10. Has a doctor ever ordered a test for your heart?	☐	☐
11. Anyone in your family died for no apparent reason?	☐	☐
12. Anyone in your family have a heart problem?	☐	☐
13. Has any family member or relative died of heart problems or sudden death before the age of 50?	☐	☐
14. Anyone in your family have Marfan syndrome?	☐	☐
15. Ever spent the night in the hospital?	☐	☐
16. Ever had surgery?	☐	☐
17. Ever had an injury like a sprain, muscle or ligament tear that caused you to miss practice/game?	☐	☐
18. Ever had any broken/fractured bones or dislocated joints?	☐	☐
19. Ever had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehab, physical therapy, a brace, cast or crutches?	☐	☐
20. Ever had a stress fracture?	☐	☐
21. Ever been told that you have or had an x-ray for *Atlantoaxial (neck) instability*?	☐	☐
22. Do you regularly use a brace or assistive device?	☐	☐
23. Do you have asthma or allergies?	☐	☐
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
25. Anyone in your family who has asthma?	☐	☐
26. Ever used an inhaler or taken asthma medication?	☐	☐
27. Were you born w/o or missing a kidney, eye, testicle or any other organ?	☐	☐
28. Ever had infectious mononucleosis within the last month?	☐	☐
29. Ever had rashes, pressure sores or other skin problems?	☐	☐
30. Ever had a herpes skin infection?	☐	☐
31. Ever had a head injury or concussion?	☐	☐
32. Been hit in head & confused or lost memory?	☐	☐
33. Ever had a seizure?	☐	☐
34. Do you have headaches with exercise?	☐	☐
35. Ever had numbness, tingling or weakness in your arms or legs after being hit or falling?	☐	☐
36. Ever been unable to move your arms or legs after being hit or falling?	☐	☐
37. When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
38. Has a doctor ever told you that you or someone in your family has sickle cell trait/disease?	☐	☐
39. Have any problems with your eyes/vision?	☐	☐
40. Do you wear glasses or contacts?	☐	☐
41. Do you wear protective eyewear?	☐	☐
42. Are you happy with your weight?	☐	☐
43. Are you trying to gain/lose weight?	☐	☐
44. Has anyone recommended you change your weight or eating habits?	☐	☐
45. Do you limit or carefully control what you eat?	☐	☐
46. Do you have any concerns you would like to discuss with a doctor?	☐	☐
FEMALES ONLY		
47. Have you ever had a menstrual period?	☐	☐
48. How old were you when you had your first period?	☐	☐
49. How many periods in the past 12 months?	☐	☐

Explain "Yes" answers here:_____

_____

_____

_____

_____

_____

Parental Consent for Physical Examination to be Performed

I hereby give consent for my child to receive a physical exam from a physician for the purpose of competing in athletics at Ernest Righetti High School and also state, that to the best of my knowledge, my answers to the family health history questions are complete and correct.

Parent/Guardian Signature: _____ Date: _____

PHYSICAL EXAMINATION

To be Completed by Physician

Name_____ **Date of Exam**_____

Height_____ **Weight**_____ **Pulse**_____ **BP**_____/_____ **Vision R 20/**_____ **L 20/**_____

Medical	Normal	Abnormal Findings	Initials*
Appearance			
Eyes/Ears/Nose/Throat			
Hearing			
Lymph Nodes			
Heart			
Lungs			
Abdomen			
Genitourinary (males only)**			
Skin			
Musculoskeletal	**Normal**	**Abnormal Findings**	**Initials***
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			

*For station-based exams only
**Having a third party present is recommended for the genitourinary exam

Medical Clearance

- ☐ Cleared without restriction
- ☐ Cleared with recommendations: _____
  _____
- ☐ Not Cleared
  - ☐ For all sports
  - ☐ Certain sports _____

  Reason: _____
  _____

I certify that I have on this date examined this student and that, on the basis of my examination requested by the school authorities and the student's medical history as furnished to me, I have found no reason which would make it inadvisable for this student to compete in supervised athletic activities. (Note exceptions above)

Name of physician (print/type) _____ Date_____

Signature of physician _____, MD or DO (circle one)