Pre-Participation Physical Evaluation

Home Address: Phone:		
Personal Physician's Name:		
Emergency Contact: Name		
Relationship:Phone: HomeWork		
Check YES or NO for questions below and explain any "yes" answers . Circle questions you don't know the answers to	<u> </u>	
check 125 of 140 for questions below and explain any yes answers. Circle questions you don't know the answers to		
	YES	NO
1. Have you had a medical illness or injury since your last check up or sports physical? Do you have an ongoing or chronic illness?		
2. Have you ever been hospitalized overnight? Have you ever had surgery?		
3. Are you currently taking any prescription or nonprescription medications or using an inhaler?		
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? 4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?		
Have you ever had a rash or hives develop during or after exercise?		
5. Have you ever passed out or been dizzy during or after exercise? Have you ever had chest pain during or after exercise?		
Do you get tired more quickly than your friends do during exercise?	H	
Have you ever had racing of your heart or skipped heartbeats?		
Have you ever had high blood pressure or high cholesterol? Have you ever been told you have a heart murmur?	H	ᆸᅵ
Has any family member or relative died of heart problems or of sudden death before age 50?		
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? Has a physician ever denied or restricted your participation in sports for any heart problems?	H	片ㅣ
6. Do you have any current skin problems (itching, rashes, acne, warts, fungus, or blisters, etc.)?		
7. Have you ever had a head injury or concussion?		
Have you ever been knocked out, become unconscious or lost your memory? Have you ever had a seizure?	H	HI
Do you have frequent or severe headaches?		
Have you ever had numbness or tingling in your arms, hands, legs, or feet?	<u> </u>	
8. Have you ever become ill from exercising in the heat?9. Do you cough, wheeze, or have trouble breathing during or after an activity?		
Do you have asthma or seasonal allergies that require medical treatment?		
10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aids, etc.)?		
11. Do you wear glasses, contacts, or protective eyewear?		
12. Have you ever had a sprain, strain, or swelling after an injury?		
Have you broken or fractured any bones or dislocated any joints?		
Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? If <i>yes</i> , check the appropriate box and explain below:		
☐ Head ☐ Neck ☐ Back ☐ Chest ☐ Shoulder ☐ Upper Arm ☐ Elbow		
☐ Forearm ☐ Wrist ☐ Hand ☐ Finger ☐ Hip ☐ Thigh ☐ Knee ☐ Shin/Calf ☐ Ankle ☐ Foot ☐ Thigh ☐ Knee		
13. Do you want to weigh more or less than you do now? Do you lose weight regularly to meet weight requirements for your sport?		
14. Record the dates of most recent immunizations: Tetanus: Chickenpox: Measles: Hepatitis	B:	
15. For Females Only: When was your first menstrual period?		
16. Have you ever tested positive or been diagnosed with COVID-19? If yes, when? YES NO Date positive	e/diagnosis_	
Please explain any "YES" answers on the other side of this form		
I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.		
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Athlete's Parent's Signature:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:		

HUNTINGTON BEACH UNION HIGH SCHOOL DISTRICT **Pre-Participation Physical Evaluation**

Student's Name:	Date of Birth:								
Height:Weight:	% of Body Fat (opti	onal):	Pulse:		_BP	/	(/	,	/
Vision: R 20/L 20/	Corrected:	Y N	Pupils:	Equal		Unequa	al		
	Normal		Abnormal F	indings	1			In	itials*
MEDICAL									
Appearance									
Eyes/Ears/Nose/Throat									
Lymph Nodes									
Heart									
Pulses									
Lungs									
Abdomen									
Genitalia (males only)									
Skin									
MUSCULOSKELETAL									
Neck									
Back									
Shoulder/Arm									
Elbow/Forearm									
Wrist/Hand									
Hip/Thigh									
Knee									
Leg/Ankle									
Foot									
* Station based examination of	only								
CLEARANCE									
Cleared and have	reviewed questionnaire on re	verse side							
Cleared after com	pleting evaluation/rehabilitati	on for:							
Not cleared for:									
PHYSICIAN'S ADI	ORESS AND SIGNA	ATURE							
						Stamp with	Name of	f Doctor	•
N. AND I. AND D. C. L.			or Medical Office/C						
Name of Physician, NP,PA (print or the Address:				_		(Kequired	to be acc	repted)	
Address:Phone:				_					
I HOHE.	Date: _			_					
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