

Preparticipation Physical Examination Form

(Please type or print)

Student's Name _____ Birth Date _____ Sex _____ Grade _____

Last First Middle

City _____ School _____ Place of Birth _____

Student's Address _____

Street City Zip Telephone

Parent(s) or Guardian(s) Name _____

Address (if different than student) _____

Street City Zip Telephone

Family Physician's Name, Address, Telephone _____

History

This section is to be carefully completed by the student and his/her parent(s) or legal guardian(s) before participation in interscholastic athletics in order to help detect possible risks.

Explain "YES" answers below. Circle questions you don't know the answer to.

<p>1. Have you had a medical illness or injury since your last checkup or sports physical? Do you have an ongoing or chronic illness?</p> <p>2. Have you ever been hospitalized overnight? Have you ever had surgery?</p> <p>3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler? Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?</p> <p>4. Do you think you are in good health?</p> <p>5. Do you have any allergies (for example, to pollen, medicine, food, or stinging insect)?</p> <p>6. Have you ever had a rash or hives develop during or after exercise? Have you ever passed out during or after exercise? Have you ever 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? Have you ever had racing of your heart or skipped heartbeats? Have you had high blood pressure or high cholesterol? Have you ever been told you have a heart murmur? Has any family member or relative died of heart problems or of sudden death before age 50? Is there a family history of heart problems in a close relative younger than age 50 (examples are enlarged heart, cardiomyopathy, long QT interval, abnormal EKG, abnormal heart rhythm)? Have you had a severe heart infection (for example, myocarditis or pericarditis)? Is there a family history of Marfan's Syndrome? Has a physician ever denied or restricted your participation in sports for any heart problem?</p> <p>7. Have you ever had a severe viral infection within the last month (for example, mononucleosis)?</p> <p>8. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus or blisters)?</p> <p>9. 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? Do you have frequent or severe headaches? Have you ever had numbness or tingling in your arms, hands, legs or feet? Have you ever had a stinger, burner or pinched nerve?</p>	<p>Yes</p> <p>No</p>	<p>Yes</p> <p>No</p>	<p>10. Have you ever become ill from exercising in the heat?</p> <p>11. Do you cough, wheeze or have trouble breathing during or after activity? Do you have asthma? Do you have seasonal allergies that require medical treatment?</p> <p>12. 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 aid)?</p> <p>13. Have you had any problems with your eyes or vision? Do you wear glasses, contacts or protective eyewear?</p> <p>14. Have you ever had a sprain, strain or swelling after 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? <i>If yes, check the appropriate box and explain below.</i> <input type="checkbox"/> Head <input type="checkbox"/> Upper Arm <input type="checkbox"/> Hand <input type="checkbox"/> Knee <input type="checkbox"/> Neck <input type="checkbox"/> Elbow <input type="checkbox"/> Finger <input type="checkbox"/> Shin/calf <input type="checkbox"/> Back <input type="checkbox"/> Forearm <input type="checkbox"/> Hip <input type="checkbox"/> Ankle <input type="checkbox"/> Chest <input type="checkbox"/> Wrist <input type="checkbox"/> Thigh <input type="checkbox"/> Foot <input type="checkbox"/> Shoulder</p> <p>15. Do you want to weigh more or less than you do now? Do you lose weight regularly to meet weight requirements for your sport?</p> <p>16. Do you feel stressed out?</p> <p>17. Record the dates of your most recent immunizations (shots) for: Tetanus _____ Measles _____ Hepatitis B _____ Chickenpox _____</p> <p>18. FEMALES ONLY When was your first menstrual period? _____ When was your most recent menstrual period? _____ How much time do you usually have from the start of one period to the start of another? _____ How many periods have you had in the last year? _____ What was the longest time between periods in the last year? _____</p> <p>19. ALL PARTICIPANTS Explain "Yes" answers here: _____ _____ _____ _____ _____ _____</p>
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NOTE: CONSENT AND HIPAA RELEASE FORMS THAT MUST BE SIGNED BY BOTH THE PARENT AND THE STUDENT ARE ON A SEPARATE SHEET.

NOTE: History and All Consent Forms Must be Completed Prior to Physical Examination

Modified from the form approved by the American Academy of Family Physicians, the American Academy of Pediatrics, the American Medical Society for Sports Medicine, the American Orthopedic Society for Sports Medicine and the American Osteopathic Academy of Sports Medicine.

Physical Examination

(Please type or print)

Student's Name _____ Birth Date _____
Last First Middle

Height _____ Weight _____ % Body Fat (optional) _____ Pulse _____ BP _____ / _____

Vision R 20/ _____ L 20/ _____ Corrected: Y N Pupils: Equal _____ Unequal _____

	Normal	Abnormal Findings	Initials*
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MEDICAL

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 only

Clearance

- Cleared
- Cleared after completing evaluation/rehabilitation for: _____

- Not cleared for: _____ Reason: _____
- Recommendations: _____

I certify that I have on this date examined this student and that, on the basis of the 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 medically inadvisable for this student to compete in supervised athletic activities (Note exceptions above).

 Physician's Name and Address (stamp or print)

If the Physician's Assistant (P.A.) or Advanced Nurse Practitioner (A.N.P.) performed the exam, name and address of collaborating physician or physician group:

 Examiner's Signature

 Date

 Examiner's Telephone Number

NOTE: History and Consent Must be Completed Prior to Physical Examination

Austin Royals Authorization Form

I hereby authorize the release and disclosure of the personal health information of _____ ("Student"), as described below, to _____ ("School").

The information described below may be released to the School principal or assistant principal, athletic director, coach, athletic trainer, physical education teacher, school nurse or other member of the School's administrative staff as necessary to evaluate the Student's eligibility to participate in school sponsored activities, including but not limited to interscholastic sports programs, physical education classes or other classroom activities.

Personal health information of the Student which may be released and disclosed includes records of physical examinations performed to determine the Student's eligibility to participate in school sponsored activities, including but not limited to the Pre-participation Evaluation form or other similar document required by the School prior to determining eligibility of the Student to participate in classroom or other School sponsored activities; records of the evaluation, diagnosis and treatment of injuries which the Student incurred while engaging in school sponsored activities, including but not limited to practice sessions, training and competition; and other records as necessary to determine the Student's physical fitness to participate in school sponsored activities.

The personal health information described above may be released or disclosed to the School by the Student's personal physician or physicians; a physician or other health care professional retained by the School to perform physical examinations to determine the Student's eligibility to participate in certain school sponsored activities or to provide treatment to students injured while participating in such activities, whether or not such physicians or other health care professionals are paid for their services or volunteer their time to the School; or any other EMT, hospital, physician or other health care professional who evaluates, diagnoses or treats an injury or other condition incurred by the student while participating in school sponsored activities.

I understand that the School has requested this authorization to release or disclose the personal health information described above to make certain decisions about the Student's health and ability to participate in certain school sponsored and classroom activities, and that the School is not a health care provider or health plan covered by federal HIPAA privacy regulations, and the information described below may be redisclosed and may not continue to be protected by the federal HIPAA privacy regulations. I also understand that the School is covered under the federal regulations that govern the privacy of educational records, and that the personal health information disclosed under this authorization may be protected by those regulations.

I also understand that health care providers and health plans may not condition the provision of treatment or payment on the signing of this authorization; however, the Student's participation in certain school sponsored activities may be conditioned on the signing of this authorization.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by a health care provider in reliance on this authorization, by sending a written revocation to the school principal (or designee) whose name and address appears below.

Name of Principal: _____
School Address: _____

This authorization will expire when the student is no longer enrolled as a student at the school.

NOTE: IF THE STUDENT IS UNDER 18 YEARS OF AGE, THIS AUTHORIZATION MUST BE SIGNED BY A PARENT OR LEGAL GUARDIAN TO BE VALID. IF THE STUDENT IS 18 YEARS OF AGE OR OVER, THE STUDENT MUST SIGN THIS AUTHORIZATION PERSONALLY.

Student's Signature Birthdate of Student, including year

Name of Student's personal representative, if applicable
I am the Student's (check one): _____ Parent _____ Legal Guardian (documentation must be provided)

Signature of Student's personal representative, if applicable Date

A copy of this signed form has been provided to the student or his/her personal representative
THE STUDENT SHALL NOT BE CLEARED TO PARTICIPATE IN INTERSCHOLASTIC ATHLETICS UNTIL THIS FORM HAS BEEN SIGNED AND RETURNED TO THE SCHOOL