



MEDICAL ELIGIBILITY FORM

Name: Date of bir	th:	
Medically eligible for all sports without restriction		
□ Medically eligible for all sports without restriction with recommendations for further evaluation		
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 apparent clinical contraindications to practice and can participate in the sport(s) as a examination findings are on record in my office and can be made available to the sc arise after the athlete has been cleared for participation, the physician may rescind t and the potential consequences are completely explained to the athlete (and parents	outlined on this form. A copy chool at the request of the po he medical eligibility until th	of the physical arents. If conditions
Name of health care professional (print or type):	Date:	
Address:	Phone:	
Signature of health care professional:		, MD, DO, NP, or PA
SHARED EMERGENCY INFORMATION		
Allergies:		
Medications:		
Other information:		
Emergency contacts:		





PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

THIS PAGE SHOULD BE PLACED IN THE MEDICAL FILE AND NOT SHARED WITH THE SCHOOL OR SPORTS ORGANIZATION

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name:	Date of birth:		
Date of examination:	Sport(s):		
Sex assigned at birth (F, M, or intersex):	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 surgical procedures.

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

GEN (Exp Circ	Yes	No	
1.	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)?		
 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)? 		
 Has anyone in your family had a pacemaker or an implanted defibrillator before age 35? 		

BON	IE AND JOINT QUESTIONS	Yes	No
14.	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?		
15.	Do you have a bone, muscle, ligament, or joint injury that bothers you?		
MED	DICAL QUESTIONS	Yes	No
16.	Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17.	Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
18.	Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19.	Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)?		
20.	Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21.	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?		
22.	Have you ever become ill while exercising in the heat?		
23.	Do you or does someone in your family have sickle cell trait or disease?		
24.	Have you ever had or do you have any prob- lems with your eyes or vision?		

MEDICAL QUESTIONS (CONTINUED)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		
FEMALES ONLY	Yes	No
29. Have you ever had a menstrual period?		
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

Explain "Yes" answers here.

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete:	
Signature of parent or guardian:	
Date:	
	-

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PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

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Date of birth:

PHYSICIAN REMINDERS

- 1. Consider additional questions on more-sensitive issues.
 - Do you feel stressed out or under a lot of pressure?
 - Do you ever feel sad, hopeless, depressed, or anxious?
 - Do you feel safe at your home or residence?
 - ٠

Name:

- During the past 30 days, did you use chewing tobacco, snuff, or dip?
- Do you drink alcohol or use any other drugs?
- Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
- Have you ever taken any supplements to help you gain or lose weight or improve your performance?
- Do you wear a seat belt, use a helmet, and use condoms?
- 2. Consider reviewing questions on cardiovascular symptoms (Q4-Q13 of History Form).

EXAMINATIO	DN								
Height:			Weight:						
BP: /	(/	′)	Pulse:	Vision: R 20/	L 20/	Correc	nrected: 🗆 Y 🗆 N		
MEDICAL							NORMAL	ABNORMAL FINDINGS	
Appearance									
				ched palate, pectus excavatum, arac	hnodactyly, hypei	rlaxity,			
			e [MVP], an	d aortic insufficiency)					
Eyes, ears, n		oat							
Pupils equ	al								
Hearing							ļ		
Lymph nodes									
Heart ^a	, h:		6		1				
	auscultation	n standir	ng, ausculta	ition supine, and ± Valsalva maneuve	er)				
Lungs									
Abdomen									
Skin	ا میں اور م			artive of methicillin resistant Standy de		DCA) or			
tinea corp		l⊓3v], i€	esions sugg	estive of methicillin-resistant Staphylo		KJAJ, Or			
Neurological									
MUSCULOS	ELETAL						NORMAL	ABNORMAL FINDINGS	
Neck									
Back									
Shoulder and	arm								
Elbow and fo									
Wrist, hand,									
Hip and thig							1		
Knee									
Leg and ankl	9								
Foot and toe									
Functional									
Double-le	g squat test,	single-l	eg squat te	st, and box drop or step drop test					
^a Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combi-									
nation of those		-						-	
	n care profe	ssional	(print or typ	pe):				te:	
Address:						Pł	none:		
Signature of h	ealth care pr	ofessior	nal:					, MD, DO, NP, or PA	

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