PREPARTICIPATION PHYSICAL EVALUATION

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Have you were had disconnected, pain, tightness, or pressure in your chest during exercise?				32. Do you have any rashes, pressure sores	s, or other skin problems?		+
Dees you four the server race or skip bears. (irregular beats) during exercise? This a doctore ever told you that you have any beart problems? If so, check all High blood pressure By High bebose pressure By High bebose pressure A beart intertain A beart intertain A beart intertain Branch blood pressure A beart intertain A beart intertain Branch blood pressure A beart intertain Branch blood pressure A beart intertain A beart intertain Branch blood pressure A beart intertain Branch blood pressure Branch blood pressure A beart intertain Branch blood pressure Branch blood pressure A beart intertain Branch blood pressure Branch blood pressure A beart intertain Branch blood pressure Branch blood pressure A beart intertain Branch blood pressure Branch blood pressure A beart intertain Branch blood pressure Branch blood pressure A beart intertain Branch blood pressure Branch blood pressure A beart intertain Branch blood pressure Branch blood pressure A beart intertain Branch blood pressure Branch blood pressure Branch blood pressure Branch blood pressure A beart intertain Branch blood pressure				33. Have you had a herpes or MRSA skin	infection?		
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Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches? Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism) Do you regularly use a brace, orthotics, or other assistive device? Do any of your joints become painful, swollen, feel warm, or look red? Do you have any history of juvenile arthritis or connective tissue disease? Perby state that, to the best of my knowledge, my answers to the above questions are complete and accurate. Signature of parent/guardian Parent's Permission & Acknowledgement of Risk for Son or Daughter to Participate in Athletics ne parent or legal guardian of the above named student-athlete, I give my permission for his/her participation in athletic events and the physical evaluation for that participation. I understand that this is simply a screation and not a substitute for regular health care. I also grant permission for treatment deemed necessary for a condition arising during participation of these events, including medical or surgical treatment mmended by a medical doctor. I grant permission to nurses, athletic trainers and coaches as well as physicians or those under their direction who are part of athletic injury prevention and treatment, to have account of the sevents, including medical or surgical treatment, to have account of the sevents, including medical or surgical treatment, to have account of the sevents and the physicians or those under their direction who are part of athletic injury prevention and treatment, to have account of the sevents and the physical doctor. I grant permission to nurses, athletic trainers and coaches as well as physicians or those under their direction who are part of athletic injury prevention and treatment, to have account of the sevents and the physical doctor. I grant permission to nurses, athletic trainers and coaches as well as physicians or those under their direction who are part of athletic	<u> </u>			54. How many periods have you had in the	e last 12 months?		
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ssary medical information. I know that the risk of injury to my child/ward comes with participation in sports and during travel to and from play and practice. I have had the opportunity to understand the risk of	ne parent or legal guardian of the above named student-athlete, I give my penation and not a substitute for regular health care. I also grant permission mmended by a medical doctor. I grant permission to nurses, athletic train	ermission for n for treatme ers and coacl	his/her participa nt deemed nece nes as well as pl	ation in athletic events and the physical evaluation for the essary for a condition arising during participation of the hysicians or those under their direction who are part of	nat participation. I understand that the hese events, including medical or su f athletic injury prevention and treats	rgical treat ment, to hav	ment tl

■ PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name		Date of Birth
EXAMINATION		
Height Weight		☐ Male ☐ Female
BP / (/) Pulse	Vision R 20/	L20/ Corrected □ Yes □ No
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly,		
arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency) Eyes/ears/nose/throat	-	
Pupils equalHearing		
Lymph nodes		
Heart ^a		
 Murmurs (auscultation standing, supine, +/- Valsalva) Location of point of maximal impulse (PMI) 		
Pulses		
Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only) ^b		
Skin HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic ^c		
MUSCOSKELETAL		
Neck		
Back		
Shoulder/arm	+	
Elbow/forearm		
	+	
Wrist/hand/fingers	+	
Hip/thigh	+	
Knee		
Leg/ankle	+	
Foot/toes		
Functional Duck-walk, single leg hop		
^a Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or estable Consider GU exam if in private setting. Having third party present is recommended. ^c Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant of		
☐ Cleared for all sports without restriction		
☐ Cleared for all sports without restriction with recommendations for further evalu	ation or treatment for	r
□ Not cleared		
☐ Pending further evaluation		
☐ For any sports		
☐ For certain sports		
Reason		
Recommendations		
I have examined the above-named student and completed the participal contraindications to practice and participate in the sport(s) as outlined about physician may rescind the clearance until the problem is resolve and parents/guardians).	ove. If conditions a	arise after the athlete has been cleared for participation, th
Name of physician (print/type)		
Address		Phone
Signature of physician		, MD or DO