Pre-Participation Physical Examination Form

S.I.A.A.
SUNSHINE INDEPENDENT ATHLETIC ASSOCIATION

This form must be completed before a student-athlete is permitted to participate in any try-outs, conditioning, weight training, practices, scrimmages, or contests for an SIAA school. This form will be kept on file by the school and is valid for 365 days from the date of evaluation. Physical must be administered **after** April 15, 2016.

For Use During the 2016-2017 School Year and 2017 Summer

Part 1. Student Information (to be completed by student or parent)

Student's Name: _____ Sex: _____ Age: _____ Date of Birth: _____/ _____/ _____

Grade in School: _____ Sport(s): _____

Home Address: _____ Home Phone: (_____) _____

Name of Parent/Guardian: _____ Cell Phone: (_____) _____

E-mail: _____

Person to Contact in Case of Emergency (if different from parent/guardian): _____

Relationship to Student: _____ Best Contact Phone: (_____) _____

Personal/Family Physician: _____ Office Phone: (_____) _____

Part 2. Medical History (to be completed by student or parent). Explain "yes" answers below.

	Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?	____	___
2. Do you have an ongoing chronic illness?	____	___
3. Have you ever been hospitalized overnight?	____	___
4. Have you ever had surgery?	____	___
5. Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler?	____	___
6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	____	___
7. Do you have any allergies (for example, pollen, latex, medicine, food or stinging insects)?	____	___
8. Have you ever had a rash or hives develop during or after exercise?	____	___
9. Have you ever passed out during or after exercise?	____	___
10. Have you ever been dizzy during or after exercise?	____	___
11. Have you ever had chest pain during or after exercise?	____	___
12. Do you get tired more quickly than your friends do during exercise?	____	___
13. Have you ever had racing of your heart or skipped heartbeats?	____	___
14. Have you had high blood pressure or high cholesterol?	____	___
15. Have you ever been told you have a heart murmur?	____	___
16. Has any family member or relative died of heart problems or sudden death before age 50?	____	___
17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	____	___
18. Has a physician ever denied or restricted your participation in sports for any heart problems?	____	___
19. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, blisters or pressure sores)?	____	___
20. Have you ever had a head injury or concussion?	____	___
21. Have you ever been knocked out, become unconscious or lost your memory?	____	___
22. Have you ever had a seizure?	____	___
23. Do you have frequent or severe headaches?	____	___
24. Have you ever had numbness or tingling in your arms, hands, legs or feet?	____	___
25. Have you ever had a stinger, burner or pinched nerve?	____	___
26. Have you ever become ill from exercising in the heat?	____	___
27. Do you cough, wheeze or have trouble breathing during or after activity?	____	___
28. Do you have asthma?	____	___
29. Do you have seasonal allergies that require medical treatment?	____	___
30. Do you use any special protective or corrective equipment or medical devices that aren't usually used for your sport or position(for example, knee brace, special neck roll, foot orthotics, shunt, retainer on your teeth or hearing aid)?	____	___
31. Have you had any problems with your eyes or vision?	____	___
32. Do you wear glasses, contacts or protective eyewear?	____	___
33. Have you ever had a sprain, strain or swelling after injury?	____	___
34. Have you broken or fractured any bones or dislocated any joints?	____	___
35. Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?	____	___
If yes, check appropriate blank and explain below:		
___ Head ___ Elbow ___ Hip ___ Neck ___ Forearm ___ Thigh ___ Back ___ Wrist ___ Knee ___ Chest ___ Hand ___ Shin/Calf ___ Shoulder ___ Finger ___ Ankle ___ Upper Arm ___ Foot		
36. Do you want to weigh more or less than you do now?	____	___
37. Do you lose weight regularly to meet weight requirements for your sport?	____	___
38. Do you feel stressed out?	____	___
39. Have you ever been diagnosed with sickle cell anemia?	____	___
40. Have you ever been diagnosed with having the sickle cell trait?	____	___
41. Record the dates of your most recent immunizations (shots) for: Tetanus: _____ Measles: _____ Hepatitus B: _____ Chickenpox: _____		

Explain "Yes" answers here:

_____

_____

We hereby state, to the best of our knowledge, that our answers to the above questions are complete and correct.

Signature of Student: _____ Date: ____/ ____/ ____

Signature of Parent/Guardian: _____ Date: ____/ ____/ ____

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Part 3. Physical Examination (to be completed by licensed physician, licensed osteopathic physician, licensed chiropractic physician, licensed physician assistant or certified advanced registered nurse practitioner).

Student's Name: _____ Date of Birth: _____/_____/_____

Height: _____ Weight: _____ Pulse: _____ Blood Pressure: ____ / ____ (____/____ , ____ /____)

Temperature: _____ Hearing: right: P _____ F _____ left: P _____ F _____

Visual Acuity: Right 20/_____ Left 20/_____ Corrected: Yes No Pupils: Equal _____ Unequal _____

FINDINGS	NORMAL	ABNORMAL FINDINGS	INITIALS
MEDICAL			
1. Appearance			
2. Eyes/Ears/Nose/Throat			
3. Lymph Nodes			
4. Heart			
5. Pulses			
6. Lungs			
7. Abdomen			
8. Genitalia (males only)			
9. Skin			
MUSCULOSKELETAL			
10. Neck			
11. Back			
12. Shoulder/Arm			
13. Elbow/Forearm			
14. Wrist/Hand			
15. Hip/Thigh			
16. Knee			
17. Leg/Ankle			
18. Foot			

ASSESSMENT OF EXAMINING PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER

I hereby certify that each examination listed above was performed by me or an individual under my direct supervision with the following conclusion(s):

____ **Cleared without limitation**

____ **Disability**: _____Diagnosis: _____

_____

____ **Precautions**: _____

_____

____ **Not cleared for**: _____ Reason: _____

_____

____ **Cleared after completing evaluation/rehabilitation for**: _____

____ **Referred to** _____ For: _____

_____

Recommendations: _____

_____

Name of Physician/Physician Assistant/Nurse Practitioner (print): _____ Date: ____/____/_____

Address: _____

Signature of Physician/Physician Assistant/Nurse Practitioner: _____

Based on recommendations developed by the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine and American Osteopathic Academy for Sports Medicine.