



2017-2018 ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

(The Parent or Guardian should fill out this form with assistance from the student athlete.)

Exam Date:

Name:

Sex:

Age:

Date of Birth:

Grade:

School:

Sport(s):

Address:

Phone:

Personal Physician:

Hospital Preference:

In case of emergency, contact:

Name:

Relationship:

Phone (Home):

(Work):

(Cell):

Name:

Relationship:

Phone (Home):

(Work):

(Cell):

Explain "Yes" answers on following page.
Circle questions you don't know the answers to.

1) Has a doctor ever denied or restricted your participation in sports for any reason?

Y	N
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

2) Do you have an ongoing medical condition (like diabetes or asthma)?

3) Are you currently taking any prescription or nonprescription (over-the-counter) medicines or supplements?
(Please specify):

<input type="checkbox"/>	<input type="checkbox"/>
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4) Do you have allergies to medicines, pollens, foods, or stinging insects?
(Please specify):

<input type="checkbox"/>	<input type="checkbox"/>
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5) Does your heart race or skip beats during exercise?

6) Has a doctor ever told you that you have (check all that apply):

High Blood Pressure ☐ A Heart Murmur ☐ High Cholesterol ☐ A Heart Infection ☐

7) Have you ever spent the night in the hospital?

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

8) Have you ever had surgery?

* 9) Have you ever had an injury (sprain, muscle/ligament tear, tendinitis, etc.) that caused you to miss a practice or game? (If yes, circle affected area in the box below):

<input type="checkbox"/>	<input type="checkbox"/>
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* 10) Have you had any broken/fractured bones or dislocated joints?
(If yes, circle affected area in the box below):

<input type="checkbox"/>	<input type="checkbox"/>
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* 11) Have you had a bone/joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? (If yes, circle affected area in the box below):

<input type="checkbox"/>	<input type="checkbox"/>
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<input type="checkbox"/> Head	<input type="checkbox"/> Neck	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Upper Arm	<input type="checkbox"/> Elbow	<input type="checkbox"/> Forearm
<input type="checkbox"/> Hand/Fingers	<input type="checkbox"/> Chest	<input type="checkbox"/> Upper Back	<input type="checkbox"/> Low Back	<input type="checkbox"/> Hip	<input type="checkbox"/> Thigh
<input type="checkbox"/> Knee	<input type="checkbox"/> Calf/Shin	<input type="checkbox"/> Ankle	<input type="checkbox"/> Foot/Toes		

	Y	N
12) Have you ever had a stress fracture?		
13) Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?		
14) Do you regularly use a brace or assistive device?		
15) Has a doctor told you that you have asthma or allergies?		
16) Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17) Is there anyone in your family who has asthma?		
18) Have you ever used an inhaler or taken asthma medicine?		
19) Were you born without, are you missing, or do you have a nonfunctioning kidney, eye, testicle or any other organ?		
20) Have you had infectious mononucleosis (mono) within the last month?		
21) Do you have any rashes, pressure sores, or other skin problems?		
22) Have you had a herpes skin infection?		
23) Have you ever had an injury to your face, head, skull or brain (including a concussion, confusion, memory loss or headache from a hit to your head, having your "bell rung" or getting "dinged")?		
24) Have you ever had a seizure?		
25) Do you have headaches with exercise?		
26) Have you ever had numbness, tingling, or weakness in your arms or legs after being hit, falling, stingers or burners?		
27) When exercising in the heat, do you have severe muscle cramps or become ill?		
28) Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?		
29) Have you ever been tested for sickle cell trait?		
30) Have you had any problems with your eyes or vision?		
31) Do you wear glasses or contact lenses?		
32) Do you wear protective eyewear, such as goggles or a face shield?		
33) Are you happy with your weight?		
34) Are you trying to gain or lose weight?		
35) Has anyone recommended you change your weight or eating habits?		
36) Do you limit or carefully control what you eat?		
37) Do you have any concerns that you would like to discuss with a doctor?		

Females Only

	Y	N
38) Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
39) How old were you when you had your first menstrual period?		
40) How many periods have you had in the last year?		

Explain "Yes" Answers Here



2017-2018 ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

(The Physician should fill out this form with assistance from the Parent or Guardian.)

Student Name:

Date of Birth:

Patient History Questions: Please tell me about your child...

- 1) Has your child fainted or passed out DURING or AFTER exercise, emotion or startle?
- 2) Has your child ever had extreme shortness of breath during exercise?
- 3) Has your child had extreme fatigue associated with exercise (different from other children)?
- 4) Has your child ever had discomfort, pain or pressure in his/her chest during exercise?
- 5) Has a doctor ever ordered a test for your child's heart?
- 6) Has your child ever been diagnosed with an unexplained seizure disorder?
- 7) Has your child ever been diagnosed with exercise-induced asthma not well controlled with medication?

Y	N
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Family History Questions: Please tell me about any of the following in your family...

- 8) Are there any family members who had sudden, unexpected, unexplained death before age 50? (including SIDS, car accidents, drowning, or near drowning)
- 9) Are there any family members who died suddenly of "heart problems" before age 50?
- 10) Are there any family members who have unexplained fainting or seizures?
- 11) Are there any relatives with certain conditions, such as:

Enlarged Heart

Hypertrophic Cardiomyopathy (HCM)
Dilated Cardiomyopathy (DCM)

Heart Rhythm problems:

Long QT Syndrome (LQTS)
Short QT Syndrome
Brugada Syndrome

Catecholaminergic Polymorphic Ventricular
Tachycardia (CPVT)

Arrhythmogenic Right Ventricular
Cardiomyopathy (ARVC)

Y	N
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Marfan Syndrome (Aortic Rupture)

Heart Attack, age 50 or younger

Pacemaker or Implanted Defibrillator

Deaf at Birth (Congenital Deafness)

Y	N
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Explain "Yes" Answers Here

I hereby state that, to the best of my knowledge, my answers to all of the above questions are complete and correct. Furthermore, I acknowledge and understand that my eligibility may be revoked if I have not given truthful and accurate information in response to the above questions.

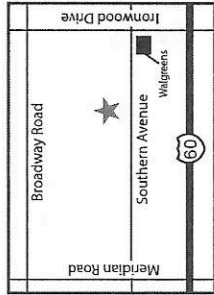
Signature of athlete

Signature of parent/guardian

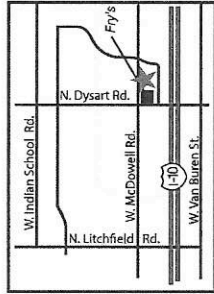
Date

Signature of MD/DO/ND/NMD/NP/PA-C/CCSP

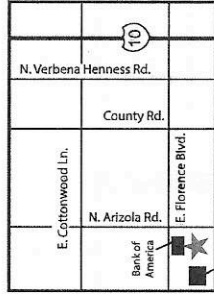
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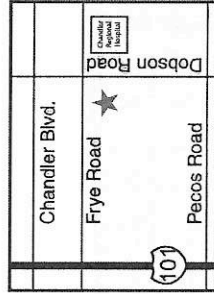
Apache Junction • 85120
2080 West Southern Ave., Suite #A1



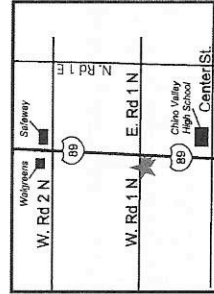
Avondale • 85392
13075 W. McDowell Rd., Suite #D106



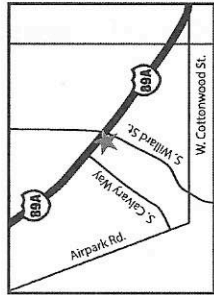
Casa Grande • 85122
1683 E. Florence Blvd., Suite #7



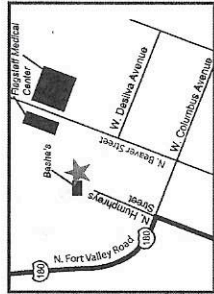
Chandler • 85224
600 S. Dobson Road, Suite C-26



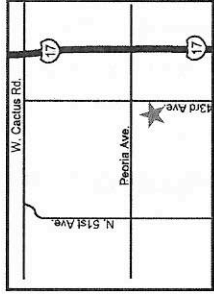
Chino Valley • 86323
474 State Highway 89



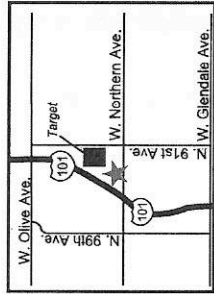
Cottonwood • 86326
450 S. Willow Street, Suite #120



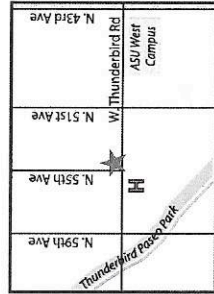
Flagstaff • 86001
1000 N. Humphreys St., Suite #104



Glendale • 85302
10240 N. 43rd Ave., Suite #3



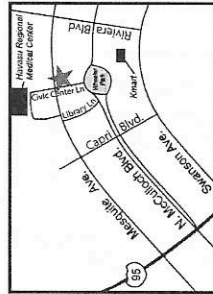
Glendale • 85305
9494 W. Northern Ave., Suite #101



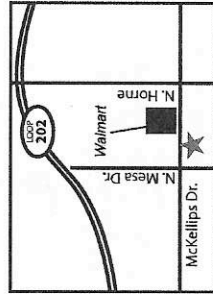
Glendale • 85306
5410 W. Thunderbird Road, Suite #101



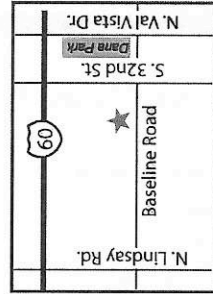
Glendale • 85308
18589 N. 59th Ave., Suite #101



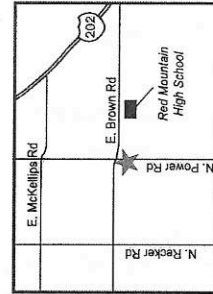
Lake Havasu City • 86403
1810 Mesquite Ave., Suite B



Mesa • 85203
535 E. McKellips Road, Suite #101



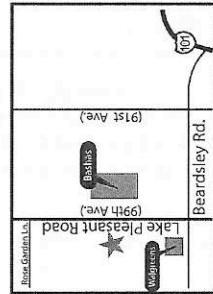
Mesa • 85204
3130 E. Baseline Road, Suite #105



Mesa • 85205
1066 N. Power Road, Suite #101



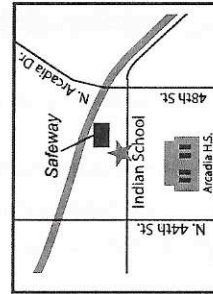
Mesa • 85215
4401 E. McKellips Road, Suite #102



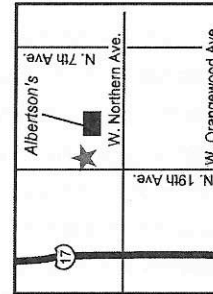
Peoria • 85382
20470 N. Lake Pleasant Rd., Suite #102



Phoenix • 85016
1701 E. Thomas Road, Suite #A104



Phoenix • 85018
4730 E. Indian School Rd., Suite #211



Phoenix • 85021
8101 N. 19th Ave., Suite #A