

# Preparticipation Physical Evaluation

## HISTORY FORM

Date of Exam \_\_\_\_\_

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_

Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Personal Physician \_\_\_\_\_

**In case of emergency, contact:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (H) \_\_\_\_\_ Phone (W) \_\_\_\_\_

**Explain "Yes" answers below.  
Circle questions you don't know the answers to.**

		Yes	No			Yes	No
1.	Has a doctor ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	24.	Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Do you have an ongoing medical condition (like diabetes or asthma)?	<input type="checkbox"/>	<input type="checkbox"/>	25.	Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	<input type="checkbox"/>	<input type="checkbox"/>	26.	Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Do you have allergies to medicines, pollens, foods, or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>	27.	Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Have you ever passed out or nearly passed out DURING exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28.	Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Have you ever passed out or nearly passed out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	29.	Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Have you ever had discomfort, pain, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	30.	Have you had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
8.	Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	31.	Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
9.	Has a doctor ever told you that you have (check all that apply):			32.	Have you been hit in the head and been confused or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> High blood pressure			33.	Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> A heart murmur			34.	Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> High cholesterol			35.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> A heart infection			36.	Have you ever been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
10.	Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram)	<input type="checkbox"/>	<input type="checkbox"/>	37.	When exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>
11.	Has anyone in your family died for no apparent reason?	<input type="checkbox"/>	<input type="checkbox"/>	38.	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
12.	Does anyone in your family have a heart problem?	<input type="checkbox"/>	<input type="checkbox"/>	39.	Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
13.	Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	40.	Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
14.	Does anyone in your family have Marfan syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	41.	Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
15.	Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	42.	Are you happy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>
16.	Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	43.	Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
17.	Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below:	<input type="checkbox"/>	<input type="checkbox"/>	44.	Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>
18.	Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	<input type="checkbox"/>	<input type="checkbox"/>	45.	Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>
19.	Have you had a bone or joint injury that required x-rays MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:	<input type="checkbox"/>	<input type="checkbox"/>	46.	Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/ Fingers	Chest
Upper Back	Lower Back	Hip	Thigh	Knee	Calf/ Shin	Ankle	Foot/ Toes
20.	Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>	47.	Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
21.	Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	<input type="checkbox"/>	<input type="checkbox"/>	48.	How old were you when you had your first menstrual period? _____		
22.	Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>	49.	How many periods have you had in the last 12 months? _____		
23.	Has a doctor ever told you that you have asthma or allergies?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Explain "Yes" answers here:</b> _____			
_____							
_____							
_____							

**FEMALES ONLY**

47. Have you ever had a menstrual period?

48. How old were you when you had your first menstrual period? \_\_\_\_\_

49. How many periods have you had in the last 12 months? \_\_\_\_\_

**Explain "Yes" answers here:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.**

Signature of Athlete \_\_\_\_\_ Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

# Preparticipation Physical Evaluation

Revised 04-13-05

**PHYSICAL EXAMINATION FORM**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ %Body Fat (optional) \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ (\_\_\_\_\_/\_\_\_\_\_, \_\_\_\_/\_\_\_\_\_)  
 Vision R 20/\_\_\_\_\_/\_\_\_\_\_ L 20/\_\_\_\_\_/\_\_\_\_\_ Corrected: Y N Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

	NORMAL	ABNORMAL FINDINGS	INITIALS*
<b>MEDICAL</b>			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only) +			
Skin			
<b>MUSCULOSKELETAL</b>			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

\* Multiple-examiner set-up only

+ Having a third party present is recommended for the genitourinary examination.

Notes: \_\_\_\_\_

# Preparticipation Physical Evaluation

**CLEARANCE FORM**

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_

Cleared without restriction  
 Cleared, with recommendations for further evaluations or treatment for: \_\_\_\_\_

Not Cleared for  All sports  Certain sports: \_\_\_\_\_ Reason: \_\_\_\_\_  
 Recommendations: \_\_\_\_\_

## EMERGENCY INFORMATION

Allergies \_\_\_\_\_

Other information \_\_\_\_\_

Name of physician (print/type) \_\_\_\_\_ Date: \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD or DO

**ATHLETIC PARTICIPATION, INSURANCE, AND CONSENT FORM**

*\*Parents signature needed in four places*

**PLEASE PRINT**

Name \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_  
(Last) (First) (Middle)

Address \_\_\_\_\_  
(Street) (City) (Zip)

The student is domiciled at the above address located in the \_\_\_\_\_ School District.

(School must be notified if student moves from the above address)

Have you attended this Paulding County school for at least one full school year? Yes \_\_\_\_\_ No \_\_\_\_\_

You live with (Name of Parent/Parents/Guardian) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

Date entered 9<sup>th</sup> grade \_\_\_\_\_ Grade level for this school year \_\_\_\_\_

**PARENTAL CONSENT FOR ATHLETIC PARTICIPATION**

**WARNING:** Although participation in supervised inter-scholastic athletics and intra-scholastic athletic clubs may be one of the least hazardous in which students will engage in or out of school, **BY ITS NATURE, PARTICIPATION IN INTER-SCHOLASTIC ATHLETICS INCLUDES A RISK OR INJURY WHICH MAY RANGE IN SEVERITY FROM MINOR TO LONG TERM CATASTROPHIC, INCLUDING PERMANENT PARALYSIS FROM THE NECK DOWN OR DEATH.** Although serious injuries are not common in supervised athletic programs or athletic clubs, it is possible only to minimize, not eliminate this risk.

Participants can and have the responsibility to help reduce the chance of injury. **PARTICIPANTS MUST OBEY ALL SAFETY RULES, REPORT ALL PHYSICAL PROBLEMS TO THEIR COACHES, FOLLOW A PROPER CONDITIONING PROGRAM, AND INSPECT THEIR EQUIPMENT DAILY.**

By signing this permission form, you acknowledge that you have read and understand this warning. **PARENTS OR STUDENTS WHO DO NOT WISH TO ACCEPT THE RISKS DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS PERMISSION FORM.**

I (We) hereby give consent for \_\_\_\_\_ to:

(1) **Compete in athletics at \_\_\_\_\_ School of the Paulding County School District in Georgia High School Association approved sports EXCEPT THOSE CROSSED out below:**

- |               |            |               |              |                 |
|---------------|------------|---------------|--------------|-----------------|
| Baseball      | Basketball | Golf          | Volleyball   | Tennis          |
| Cross Country | Football   | Softball      | Wrestling    | Weight Training |
| Rifle Team    | Soccer     | Track & Field | Cheerleading |                 |

- (2) To accompany any school team of which the student is a member on any of its local or out-of-town trips;
- (3) and, I hereby verify that the information on both sides of this form is correct and understand that any false information may result in my son/daughter being declared ineligible.
- (4) Parents should contact Head Coach for information regarding injuries to their son/daughter.

This acknowledgement of risk and consent to allow participation shall remain in effect until revoked in writing.

\_\_\_\_\_  
\*SIGNATURE(S) OF PARENT(S) OR GUARDIAN(S)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF STUDENT-ATHLETE

\_\_\_\_\_  
DATE

GRADE \_\_\_\_\_

MIDDLE NAME \_\_\_\_\_

FIRST NAME \_\_\_\_\_

LAST NAME \_\_\_\_\_

**PAULDING COUNTY SCHOOL DISTRICT PERMISSION TO PARTICIPATE  
IN ATHLETIC TEAM ONE-DAY SCHOOL-SPONSORED TRIPS**

**CONSENT**

I hereby consent for \_\_\_\_\_ (student's name) to participate in school-sponsored trips, excluding overnight trips, associated with inter-scholastic athletic competitions. I understand that transportation may or may not be provided by the Paulding County School District. In the event transportation is not provided by the Paulding County School District, transportation will be the student's responsibility.

If any emergency medical procedures or treatment are required by the student during the trip, I consent to the trip supervisor(s) taking, arranging for, and consenting to the procedures or treatment in his/her discretion.

I release and waive, and further agree to indemnify, hold harmless or reimburse the Paulding County School District, the Board of Education, its successors and assigns, its members, agents, employees and representatives thereof, as well as trip supervisors, from and against, any claim which I, any other parent or guardian, any sibling, the student, or any other person, firm or corporation may have or claim to have, known or unknown, directly or indirectly, from any losses, damages or injuries arising out of, during, or in connection with the student's participation in the activity, any trip associated with the activity, or the rendering or emergency medical procedures or treatment, it any.

**Signatures of Parents(s) or guardian(s) \_\_\_\_\_ Date \_\_\_\_\_**

**INSURANCE INFORMATION**

Please INITIAL one of the following statements regarding insurance coverage for your son/daughter for the 2004-2005 school year, then sign below:

\_\_\_\_ My son/daughter is adequately and currently covered by accident insurance that will cover injuries sustained while participating in inter-scholastic Athletics (including, but not limited to, Varsity, Junior Varsity and 9<sup>th</sup> grade Football), and intra-scholastic clubs and activities.

Company Providing Insurance: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_  
Policy Number: \_\_\_\_\_

\_\_\_\_ I wish to purchase the Benefit Plan provided by the Paulding County School System. (A signed copy of this Benefit Plan should be stapled to this form.)

**\*SIGNATURE(S) OF PARENT(S) OR GUARDIAN(S) \_\_\_\_\_**  
**Date \_\_\_\_\_**

**AUTHORIZATION**

I understand that per The Georgia High School Association a **Preparticipation Physical Evaluation** must be performed by a physician to medically screen each student who participates in the athletic programs of the Paulding County School District. I further understand that a basic medical screening (the required physical exam) is general in nature and limited in its scope and does not indicate or assure me that my child is completely free from impairments. If I wish for a more detailed physical exam to be performed upon my child/ward then it is my responsibility to arrange and pay for such an exam. If this more detailed exam is performed, it is my responsibility to notify the Paulding County School District, and its appropriate employees, of any potential medical problems uncovered by any physical exam given to my child/ward other than the general physical required by the school system for athletic participation. I agree to fully waive any and all claims of whatever nature, fully and finally, now and forever, for my child/ward, for myself, my estate, my heirs, my administrators, my executors, my assignees, my agents, my successors, and for all members of my family, and to indemnify, release, defend, exonerate, discharge and hold harmless the Paulding County School District, their schools, their trustees, officers, Board members, Board of Education, employees, agents, coaches, athletic trainers, physicians, and any other practitioner of the healing arts (an "Indemnified Party") from any and all liability, personal or property damages, claims, causes of action or demands brought against the Paulding County School District or indemnified party arising out of any injuries to my child/ward or to his or her property or losses of any kind which may result from or in connection with his or her participation in any activity related to the athletic programs provided by the Paulding County School District.

**My signature below attest that I have read, understand and concur with the information on this form, and that I give consent for my child to participate in the athletic programs as stated above.**

**\*SIGNATURE(S) OF PARENT(S) OR GUARDIAN(S) \_\_\_\_\_**  
**Relation to Student: (Please check one) Date \_\_\_\_\_**  
**Mother \_\_\_\_\_**  
**Father \_\_\_\_\_**  
**Other \_\_\_\_\_ Phone (W) \_\_\_\_\_ (H) \_\_\_\_\_**