# PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

This **MEDICAL HISTORY FORM** must be completed ***annually*** by parent (or guardian) and student in order for the student to participate in athletic activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an athletic event.

Student's Name: (print) _____ Sex _____ Age _____ Date of Birth _____

Address _____ Phone _____

Grade _____ School _____

Personal Physician _____ Phone _____

*In case of emergency, contact:*

Name _____ Relationship _____ Phone (H) _____ (W) _____

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

| | | Yes | No |
|---|---|---|---|
| 1. | Have you had a medical illness or injury since your last check up or sports physical? | ☐ | ☐ |
| 2. | Have you been hospitalized overnight in the past year? | ☐ | ☐ |
| | Have you ever had surgery? | ☐ | ☐ |
| 3. | Have you ever had prior testing for the heart ordered by a physician? | ☐ | ☐ |
| | Have you ever passed out during or after exercise? | ☐ | ☐ |
| | Have you ever had chest pain during or after exercise? | ☐ | ☐ |
| | Do you get tired more quickly than your friends do during exercise? | ☐ | ☐ |
| | Have you ever had racing of your heart or skipped heartbeats? | ☐ | ☐ |
| | Have you had high blood pressure or high cholesterol? | ☐ | ☐ |
| | Have you ever been told you have a heart murmur? | ☐ | ☐ |
| | Has any family member or relative died of heart problems or of sudden unexpected death before age 50? | ☐ | ☐ |
| | Has any family member been diagnosed with enlarged heart, (dilated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome or other ion channelpathy (Brugada syndrome, etc), Marfan's syndrome, or abnormal heart rhythm? | ☐ | ☐ |
| | Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? | ☐ | ☐ |
| | Has a physician ever denied or restricted your participation in sports for any heart problems? | ☐ | ☐ |
| 4. | Have you ever had a head injury or concussion? | ☐ | ☐ |
| 4. | Have you ever been knocked out, become unconscious, or lost your memory? | ☐ | ☐ |
| | If yes, how many times? _____ | | |
| | When was your last concussion? _____ | | |
| | How severe was each one? (Explain below) | | |
| | Have you ever had a seizure? | ☐ | ☐ |
| | Do you have frequent or severe headaches? | ☐ | ☐ |
| | Have you ever had numbness or tingling in your arms, hands, legs or feet? | ☐ | ☐ |
| | Have you ever had a stinger, burner, or pinched nerve? | ☐ | ☐ |
| 5. | Are you missing any paired organs? | ☐ | ☐ |
| 6. | Are you under a doctor's care? | ☐ | ☐ |
| 7. | Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler? | ☐ | ☐ |
| 8. | Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? | ☐ | ☐ |
| 9. | Have you ever been dizzy during or after exercise? | ☐ | ☐ |
| 10. | Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? | ☐ | ☐ |
| 11. | Have you ever become ill from exercising in the heat? | ☐ | ☐ |
| 12. | Have you had any problems with your eyes or vision? | ☐ | ☐ |

| | | Yes | No |
|---|---|---|---|
| 13. | Have you ever gotten unexpectedly short of breath with exercise? | ☐ | ☐ |
| | Do you have asthma? | ☐ | ☐ |
| | Do you have seasonal allergies that require medical treatment? | ☐ | ☐ |
| 14. | Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? | ☐ | ☐ |
| 15. | Have you ever had a sprain, strain, or swelling after injury? | ☐ | ☐ |
| | Have you broken or fractured any bones or dislocated any joints? | ☐ | ☐ |
| | Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? | ☐ | ☐ |
| | If yes, check appropriate box and explain below: | | |

| | | |
|---|---|---|
| ☐ Head | ☐ Elbow | ☐ Hip |
| ☐ Neck | ☐ Forearm | ☐ Thigh |
| ☐ Back | ☐ Wrist | ☐ Knee |
| ☐ Chest | ☐ Hand | ☐ Shin/Calf |
| ☐ Shoulder | ☐ Finger | ☐ Ankle |
| ☐ Upper Arm | ☐ Foot | |

| | | | |
|---|---|---|---|
| 16. | Do you want to weigh more or less than you do now? | ☐ | ☐ |
| 17. | Do you feel stressed out? | ☐ | ☐ |
| 18. | Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease? | ☐ | ☐ |

*Females Only*

19. When was your first menstrual period? _____
When was your most recent menstrual period? _____
How much time do you usually have from the start of one period to the start of another? _____
How many periods have you had in the last year? _____
What was the longest time between periods in the last year? _____

*Males Only*

20. Do you have two testicles? _____
21. Do you have any testicular swelling or masses? _____

**An individual answering in the affirmative to any question relating to a possible cardiovascular health issue (question three above), as identified on the form, should be restricted from further participation until the individual is examined and cleared by a physician, physician assistant, chiropractor, or nurse practitioner.**

**EXPLAIN 'YES' ANSWERS IN THE BOX BELOW (attach another sheet if necessary):

_____
_____
_____
_____

It is understood that even though protective equipment is worn by the athlete, whenever needed, the possibility of an accident still remains. Neither The Mountain View Los Altos School District nor the school assumes any responsibility in case an accident occurs.

If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given said student by any physician, athletic trainer, nurse or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student.

If, between this date and the beginning of athletic competition, any illness or injury should occur that may limit this student's participation, I agree to notify the school authorities of such illness or injury.

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

Student Signature: _____ Parent/Guardian Signature: _____ Date: _____

***For School Use Only:***

This Medical History Form was reviewed by: Printed Name _____ Date _____ Signature _____

**PREPARTICIPATION PHYSICAL EVALUATION -- PHYSICAL EXAMINATION**

Student's Name _____ Sex _____ Age _____ Date of Birth_____

Height _____ Weight_____ % Body fat (optional) _____ Pulse _____ BP____/____ (____/____, ____/____)
brachial blood pressure while sitting

Vision: R 20/_____ L 20/___ Corrected: ☐ Y ☐ N Pupils: ☐ Equal ☐ Unequal

As a minimum requirement, this **Physical Examination Form** must be completed prior to high school athletic participation. It ***must*** be completed if there are yes answers to specific questions on the student's MEDICAL HISTORY FORM on the reverse side. ****MVLA Board policy requires an annual physical exam****

| | NORMAL | ABNORMAL FINDINGS | INITIALS* |
|---|---|---|---|
| **MEDICAL** | | | |
| Appearance | | | |
| Eyes/Ears/Nose/Throat | | | |
| Lymph Nodes | | | |
| Heart-Auscultation of the heart in the supine position. | | | |
| Heart-Auscultation of the heart in the standing position. | | | |
| Heart-Lower extremity pulses | | | |
| Pulses | | | |
| Lungs | | | |
| Abdomen | | | |
| Genitalia (males only) | | | |
| Skin | | | |
| Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis) | | | |
| **MUSCULOSKELETAL** | | | |
| Neck | | | |
| Back | | | |
| Shoulder/Arm | | | |
| Elbow/Forearm | | | |
| Wrist/Hand | | | |
| Hip/Thigh | | | |
| Knee | | | |
| Leg/Ankle | | | |
| Foot | | | |
| | | | |

*station-based examination only

**CLEARANCE**

☐ Cleared

☐ Cleared after completing evaluation/rehabilitation for: _____

_____

☐ Not cleared for:_____Reason: _____

Recommendations: _____

_____

*The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination forms signed by any other health care practitioner, will not be accepted.*

Name (print/type) _____ Date of Examination: _____

Address: _____

Phone Number: _____

Signature: _____

Must be completed before a student participates in any tryout, practice, before, during or after school, (both in-season and out-of-season) or games/matches.