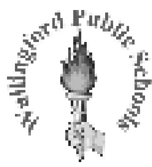

WALLINGFORD PUBLIC SCHOOLS
PREPARTICIPATION PHYSICAL EVALUATION FORM

History Form *(Note: This portion is to be filled out by the student-athlete and parent.)*

Name ______________________________ **Date of Birth** ____________________

Sex _______ **Age** __________ **Grade** __________ **School** ______________________________

Sport(s) ______________________, ______________________, ______________________

Explain "YES" answers below:	**Yes**	**NO**
1. Have you ever been hospitalized? Have you ever had surgery?	__________ __________	__________ __________
2. Are you presently taking any medications or pills?		
3. Do you have any allergies? If yes, please identify allergy: ▢ Food ▢ Medicines ▢ Pollens ▢ Stinging Insects		
4. Have you ever passed out during or after exercise? Have you ever been dizzy during or after exercise? Have you ever had chest pain during or after exercise? Do you tire more quickly than your friends during exercise? Have you ever had high blood pressure? Have you ever been told that you have a heart murmur? Have you ever had racing of your heart or skipped heartbeats? Has anyone in your family died of heart problems or a sudden death before age 50?	__________ __________ __________ __________ __________ __________ __________ __________	__________ __________ __________ __________ __________ __________ __________ __________
5. Do you have any skin problems (itching, rashes, and acne)?		
6. Have you ever had a head injury? Have you ever been knocked out or unconscious? Have you ever had a seizure? Have you ever had a stinger, burner or pinched nerve?	__________ __________ __________ __________	__________ __________ __________ __________
7. Have you ever had heat or muscle cramps? Have you ever been dizzy or passed out in the heat?	__________ __________	__________ __________
8. Do you have trouble breathing or do you cough during or after activity?		
9. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc,)?		
10. Have you had any problems with your eyes or vision? Do you wear glasses or contacts or protective eyewear?	__________ __________	__________ __________
11. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints? If yes, check <u>all</u> that apply: ____ Head ____ Shoulder ____ Thigh ____ Neck ____ Elbow ____ Knee ____Chest ____ Forearm ____ Shin/Calf ____ Back ____ Wrist ____ Ankle ____ Hip ____ Hand ____ Foot		
12. Have you had any other medical problems (infectious, mononucleosis, diabetes, etc.)?		
13. Have you had a medical problem or injury since your last evaluation?		

14. When was your last tetanus shot? ____________________ When was your last measles immunization? ____________________

15. When was your first menstrual period? ____________________ When was your last menstrual period? ____________________

What was the longest time between your periods last year? ______________________________

Explain "Yes" answer(s) ____

____

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

Signature of Parent/Guardian ______________________________ ***Date*** ____________________

Signature of Student/Athlete ______________________________ ***Date*** ____________________

Form# 9E

WALLINGFORD PUBLIC SCHOOLS
PREPARTICIPATION PHYSICAL EVALUATION FORM (continued)

Physical Examination *(Note: This portion is to be filled out by your physician.)*

Name ____________________ **Age** __________ **Date of Birth** ______________

Date of Exam ____

Height ______________ **Weight** ____________ **BP** ________/________ **Pulse** ____________

Vision R20/ ____________ **L20/** ____________ **Corrected:** Y N **Pupils** ________________

	NORMAL	ABNORMAL FINDINGS	INITIALS
Cardiopulmonary			
Pulses			
Heart			
Lungs			
Tanner Stage	1	2 3 4 5	
Skin			
Abdominal			
Genitalia			
Musculoskeletal			
Neck			
Shoulder			
Elbow			
Wrist			
Hand			
Back			
Knee			
Ankle			
Foot			
Other			

Clearance:

A. Cleared
B. Cleared after completing evaluation/rehabilitation for: ______________________________
C. Not Cleared for: ______ Collision ______ Contact ______ Non-Contact ______ Strenuous ______
______ Moderately Strenuous ______ Non-Strenuous

Due to ____

____

Recommendation ____

____

____

Name of Physician (PRINT) ______________________________ Date ______________
Physician Address ______________________________ Phone ______________

Signature of Physician ____

(Developed by the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopedic Society for Sports Medicine and American Osteopathic Academy of Sports Medicine, Copyright 1992.)