MITCHELL ROAD CHRISTIAN ACADEMY
PREPARTICIPATION PHYSICAL EVALUATION

(Form must be completed and signed by both student and parent).

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

Student's Name ________________________ Date of Birth _____ / ______ / ______ Age ___________ Sex ___________

School ______________________________ Grade ___________ Sport(s) ______________________

Home Address ______________________________________ Home Phone (_____) _______________

Name of Parent/Guardian ____

Emergency Contact Person ____

Relationship to Student ____________________ Home Phone (_____) _______________ Work Phone (_____) _______________

Personal/Family Physician ________________________ City/State ________________ Office Phone (_____) _______________

Part 2. Medical History (must be completed and signed by student and parent). Please check (Yes) or (No) after each question.

		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 nonprescription (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, to pollen, 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, or blisters)?	___	___
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 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)?	___	___
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	

		Yes	No
36.	Are you diabetic - taking shots and/or on an insulin pump?	___	___

37. Record the dates of your most recent immunizations (shots) for:

Tetanus __________ Measles ____________

Hepatitis 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 ________________________ Signature of Parent ______________________ Date ___________

PREPARTICIPATION PHYSICAL EVALUATION (Page 2)

Part 3. Physical Examination (to be completed by physician)

Student's Name ______________________________ Date of Birth ______ / _______ / _______

Height ___________ Weight __________________ Pulse ___________ Blood Pressure ____/_______(_______/_______,_______/_______)

% Body Fat (optional) ________

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. Pulse	________	______________________________	________
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	________	______________________________	________

* - station-based examination only

ASSESSMENT OF EXAMINING PHYSICIAN

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

_______ Cleared without limitation

_______ Not Cleared for: ______________________________ Reason: ______________________

____

_______ Cleared after completing evaluation/rehabilitation for: ______________________________

_______ Referred to ______________________________ For: ______________________

____

Recommendations: ____

____

Name of Physician (print or type): ______________________________ Date: ______________________

Address: ____

Signature of Physician: ______________________________ , MD, DO, DC, ARNP

ASSESSMENT OF PHYSICIAN TO WHOM REFERRED (if applicable)

I hereby certify that each examination(s) for which referred was/were performed by myself or an individual under my direct supervision with the following conclusion(s):

_______ Cleared without limitation

_______ Not Cleared for: ______________________________ Reason: ______________________

____

_______ Cleared after completing evaluation/rehabilitation for: ______________________________

Recommendations: ____

____

Name of Physician (print or type): ______________________________ Date: ______________________

Address: ____

Signature of Physician: ______________________________ , MD, DO, DC, ARNP

Based on recommendations 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 the American Osteopathic Academy for Sports Medicine.