PRE-PARTICIPATION EXAMINATION FORM

Instructions for completing pre-participation (athletic) Health Examination and Consent Form

COMPLETING THIS FORM:
1. PLEASE TYPE OR PRINT LEGIBLY
2. Parent/Guardian along with the student are to complete the Health History on page 3 and the Disclosure and Consent Document on page 2. Please note student and parent are to sign both forms. The Health History is to be taken to the physical examination for the physician/provider to review.
3. Physician/Provider is to complete and sign the Physical Examination form on page 4.
4. Entire completed form is to be returned to school administration.

SUBMITTING THIS FORM:
1. School personnel should review form to assure it is completed properly.
2. ORIGINAL copy is to be retained in school files.

A health examination must be performed annually and the Pre-participation Physical Evaluation Form must be completed before any student may participate in athletic activities sponsored by this Association. A Pre-participation Physical Evaluation Form along with the Disclosure and Consent Document must be on file at the school before any participation in athletic activities.

The health examination may be completed and the form signed by any Medical Doctor (MD), Doctor of Osteopathy (DO), Physician’s Assistant (PAC), Chiropractic Physician (DC), or Registered Nurse Practitioner (RNP) functioning within the legal scope of their practice.

THE UTAH HIGH SCHOOL ACTIVITIES ASSOCIATION DOES NOT PROVIDE PRINTED COPIES OF THIS FORM. PLEASE MAKE ALL NECESSARY COPIES.
Participant & Parental Disclosure and Consent Document

PLEASE NOTE: It is the responsibility of the parent/guardian to notify the school if there are any unique individual problems that are not listed on the Pre-participation Physical Evaluation Form.

Name of Student ____________________________ School ____________________________

Is the student covered by health/accident insurance?  □ Yes  □ No

Name of health insurance provider ____________________________
If no insurance provider, explain ____________________________

CONSENT FORM

Parent or Guardian Statement of Permission, Approval, and Acknowledgement:
By signing below, I the parent or legal guardian of the above named student do:

- Hereby consent to the above named student participating in the interscholastic athletic program at the school listed above. This consent includes travel to and from athletic contests and practice sessions.
- Further consent to treatment deemed necessary by health care providers designated by school authorities for any illness or injury resulting from his/her athletic participation.
- Recognize that a risk of possible injury is inherent in all sports participation. I further realize that potential injuries may be severe in nature including such conditions as: fractures, brain injuries, paralysis or even death.
- Acknowledge and give consent that a copy of this form will remain in the student’s school. I agree that if my student’s health changes and would alter this evaluation, I will notify the school as soon as possible but within no longer than 10 days.
- Hereby acknowledge having received education including receiving written information regarding the signs, symptoms, and risks of sport related concussion. I also acknowledge that I have read, understand and agree to abide by the UHSAA Concussion Management Policy and/or the policy of the school listed above. http://www.uhsaa.org/SportsMed/ConcussionManagementPlan.pdf

Parent or Guardian Name ____________________________ Parent or Guardian Signature ____________________________

Date ____________________________

Student Statement

By signing below I acknowledge:

- This application to compete in interscholastic athletics for the above school is entirely voluntary on my part and is made with the understanding that I have not violated any of the eligibility rules and regulations of the Utah High School Activities Association.
- My responsibility to report to my coaches and parent(s)/guardian(s) illness or injury I experience.
- Having received education including receiving written information regarding signs, symptoms, and risks of sport related concussion. I also acknowledge my responsibility to report to my coaches and parent(s)/guardian(s) any signs or symptoms of a concussion.

Signature of Student ____________________________ Date ____________________________

THIS FORM MUST BE ON FILE AT THE MEMBER HIGH SCHOOL PRIOR TO PARTICIPATION.
**Preparticipation Physical Evaluation**

**HISTORY FORM**

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam: ____________________________ Date of birth: ____________________________

Sex: ___________ Age: ___________ Grade: ___________ School: ___________________________ Sport(s): ___________________________

**Medicines and Allergies:** Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Do you have any allergies?  ____ Yes  ____ No  If yes, please identify specific allergy below:

☐ Medicines  ☐ Pollens  ☐ Food  ☐ Stinging Insects

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

**GENERAL QUESTIONS**

Yes  ____ No

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

2. Do you currently have any ongoing medical conditions? If so, please identify below:  ____ Asthma  ____ Anemia  ____ Diabetes  ____ Infections  ____ Other: ____________________________

3. Have you ever spent the night in the hospital?  ____

4. Have you ever had surgery?  ____

**HEART HEALTH QUESTIONS ABOUT YOU**

Yes  ____ No

5. Have you ever passed out or nearly passed out DURING or AFTER exercise?  ____

6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?  ____

7. Does your heart race or skip beats (irregular beats) during exercise?  ____

8. Has a doctor ever told you that you have any heart problems? If so, check all that apply:
   - High blood pressure  ____
   - A heart murmur  ____
   - High cholesterol  ____
   - A heart infection  ____
   - Kawasaki disease  ____
   - Other: ____________________________

9. Has a doctor ever ordered a test for your heart? (For example, ECG/EMG, echocardiogram)  ____

10. Do you get lightheaded or feel more short of breath than expected during exercise?  ____

11. Have you ever had an unexplained seizure?  ____

12. Do you get more tired or short of breath more quickly than your friends during exercise?  ____

**HEART HEALTH QUESTIONS ABOUT YOUR FAMILY**

Yes  ____ No

13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?  ____

14. Does anyone in your family have hypertrrophic cardiomyopathy, Marfan syndrome, amyloidotic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?  ____

15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?  ____

16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?  ____

**BONE AND JOINT QUESTIONS**

Yes  ____ No

17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?  ____

18. Have you ever had any broken or fractured bones or dislocated joints?  ____

19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?  ____

20. Have you ever had a stress fracture?  ____

21. Have you ever been told that you have or have had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfishism)  ____

22. Do you regularly use a brace, orthotics, or other assistive device?  ____

23. Do you have a bone, muscle, or joint injury that bothers you?  ____

24. Do any of your joints become painful, swollen, feel warm, or look red?  ____

25. Do you have any history of juvenile arthritis or connective tissue disease?  ____

MEDICAL QUESTIONS

Yes  ____ No

26. Do you cough, wheeze, or have difficulty breathing during or after exercise?  ____

27. Have you ever used an inhaler or taken asthma medicine?  ____

28. Is there anyone in your family who has asthma?  ____

29. Were you born without or ure are you missing a kidney, an eye, a testicle (male), your spleen, or an other organ?  ____

30. Do you have gout, a painful bunion or hernia in the groin area?  ____

31. Have you had Influenza (flu) within the last month?  ____

32. Do you have any rashes, pressure sores, or other skin problems?  ____

33. Have you had a herpes or HIV skin infection?  ____

34. Have you ever had a head injury or concussion?  ____

35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?  ____

36. Do you have a history of seizure disorder?  ____

37. Do you have headaches with exercise?  ____

38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?  ____

39. Have you ever been unable to move your arms or legs after being hit or falling?  ____

40. Have you ever become ill while exercising in the heat?  ____

41. Do you get frequent muscle cramps when exercising?  ____

42. Do you or someone in your family have sickle cell trait or disease?  ____

43. Have you had any problems with your eyes or vision?  ____

44. Have you had any eye injuries?  ____

45. Do you wear glasses or contact lenses?  ____

46. Do you wear protective eyewear, such as goggles or a face shield?  ____

47. Do you worry about your weight?  ____

48. Are you trying to or has anyone recommended that you gain or lose weight?  ____

49. Are you on a special diet or do you avoid certain types of foods?  ____

50. Have you ever had an eating disorder?  ____

51. Do you have any concerns that you would like to discuss with a doctor?  ____

**FEMALES ONLY**

52. Have you ever had a menstrual period?  ____

53. How old were you when you had your first menstrual period?  ____

54. 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: ____________________________

©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reproduce this form for noncommercial, educational purposes with acknowledgment.
Preparticipation Physical Evaluation Form

**PHYSICIAN REMINDERS**

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you have a history of alcohol or drug abuse?
   - Have you ever been treated for a heart condition?
   - Have you ever taken any medications that could affect your heart?
   - Have you ever had heart surgery or bypass surgery?
   - Have you ever had a heart attack?
   - Have you ever been diagnosed with diabetes?
   - Have you ever had a stroke?
   - Have you ever had a serious illness that required hospitalization?
   - Have you ever been diagnosed with a serious medical condition?

2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

---

### EXAMINATION

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Male</th>
<th>Female</th>
<th>Pulse</th>
<th>Vision 20/20</th>
<th>L 20/20</th>
<th>Corrected</th>
</tr>
</thead>
</table>

**MEDICAL**

- **Appearance**
  - Marfan syndrome (kyphoscoliosis, high-arched palate, pectus excavatum, arrhythmia, myopia, MVP, mitral insufficiency)

- **Eyes/ears/mouth/nose**
  - Pupils equal
  - Hearing

- **Lymph nodes**
  - Swollen

- **Heart**
  - Murmurs (auscultation standing, supine, +/– Valsalva)
  - Location of point of maximal impulse (PMI)

- **Pulse**
  - Simultaneous femoral and radial pulse

- **Lungs**

- **Abdomen**

- **Genitourinary (males only)**

- **Skin**
  - HSV lesions suggestive of MRSA, lice corporis

- **Neurologic**

**MUSCULOSKELETAL**

- **Neck**

- **Back**

- **Shoulder/Arm**

- **Elbow/Forearm**

- **Wrist/hand/fingers**

- **Hip/thigh**

- **Knee**

- **Leg/ankle**

- **Foot/feet**

- **Functional**
  - Duck-walk, single leg hop

*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

*Consider GI exam if in private setting. Having third party present is recommended.

*Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for

☐ Not cleared

☐ Pending further evaluation

☐ For any sports

☐ For certain sports

Reason

**Recommendations**

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) __________________________ Date __________________________

Address __________________________________________ Phone ________________

Signature of physician __________________________