Birmingham Public Schools Preparticipation Physical Evaluation

HISTORY		DATE OF EXAM			A current-year physical is one given on or after April 15 of the previous school year.				
١	Name				Se	xAge	Date of birth		_
C	GradeSchool	Spor	rts			-	_		_
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	In case of emergency, co								_
	• •	Relationship_				Phone (H)	(W)		
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	Turlein "Voo" answers held								
	Explain "Yes" answers belov Circle questions you don't k		Yes	No				Yes	No
1.	Have you had a medical illne check up or sports physical?				10.	Do you use any special prequipment or devices that	rotective or corrective aren't usually used for your		
	Do you have an ongoing or o	chronic illness?				sport or position (for exam	ple knee brace, special		
2.	Have you ever been hospital Have you ever had surgery?					neck roll, foot orthotics, rehearing aid)?	tainer on your teeth,		
3.	Are you currently taking any	prescription or			11.	Have you had any problem	ns with your eyes or vision?		
	nonprescription (over the cou using an inhaler?	unter medications) or pills or				Do you wear glasses, con eyewear?			
	Have you ever taken any sur	pplements or vitamins to help			12.	Have you ever had a sprain	in, strain or swelling after		
4.	you gain or lose weight or im Do you have any allergies (fo					injury? Have you broken or fractu	red any bones or dislocated		П
4.	medicine, food, or stinging in	nsects)?				any joints?			
	Have you ever had a rash or exercise?	r hives develop during or after				Have you had any other poswelling in muscles, tendo			
5.	Have you ever passed out do	uring or after exercise?				If yes, check appropriate b	box and explain below.		
	Have you ever been dizzy du	uring or after exercise?				□ Head □ Flbow	/ ☐ Hip		
	Have you ever had chest pai Do you get tired more quickly	in during or after exercise? y than your friends do during				□ Neck □ Forea □ Back □ Wrist	<u> </u>		
	exercise?			_		☐ Chest ☐ Hand	☐ Shin/calf		
	Have you ever had racing of heartbeats?	your heart or skipped				☐ Shoulder ☐ Finger☐ Upper arm	r □ Ankle □ Foot		
	Have you had high blood pre				13.	Do you want to weigh mor	re or less than you do now?		
	Have you ever been told you Has any family member died					Do you lose weight regula requirements for your spor			Ц
	sudden death before age 50°)?			14.	Do you feel stressed out?			
	Have you had a severe viral myocarditis or mononucleosi				15.	Record the date of your m	nost recent immunizations (if	known)	for:
	Has a physician ever denied	l or restricted your				Tetanus	Measles		
c	participation in sports for any	y heart problems?				Hepatitis B	Chickenpox		
6.	Do you have any current skir itching, rashes, acne, warts,			Ц	FEN	ALES ONLY			
7.	Have you ever had a head in	njury or concussion?			16.	When was your first mens			
	Have you ever been knocked or lost your memory?	d out, become unconscious,				When was your most rece			
	Have you ever had a seizure					period to the start on anot	sually have from the start of on the start of the start o	one 	
	Do you have frequent or several Have you ever had numbnes					How many periods have y	ou had in the last year?		_
	hands legs or feet?				Exp	What was the longest time ain "Yes" answers here:	e between in the last year		
8.	Have you ever had a stinger, Have you ever become ill fro								_
8. 9.	Do you cough, wheeze, or ha								
	or after activity?	-	_	_					_
	Do you have asthma? Do you have seasonal allerg	ies that require medical							
	treatment?								_
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		the disclosure to the MHSA scholastic athletics. I also h							3 ()
	estions are complete and co		10102,	/ 5.6.5	, uiui,	to the book of my mis	ago, my anomoro to are t	300 V C	
-	·								
Sic	gnature of athlete	Sig	natur	e of pa	arent/g	juardian	Date		_

Preparticipation Physical Evaluation

Name		Date of birth						
Height Weight	% Body fat (optional)	Pulse BP_	((
	Corrected: Y N							
VISION R 20/ L 20/	Corrected. 1 IN	Fupiis. Equal	Onequal					
	NORMAL	ABNORMAL FINDING	SS	INITIALS				
MEDICAL								
Appearance								
Eyes/Ears/Nose/Throat								
Lymph Nodes								
Heart								
Pulses								
Lungs								
Abdomen								
Genitalia (Males only)								
Skin								
MUSCULOSKELETAL								
Neck								
Back								
Shoulder/arm								
Elbow/forearm								
Wrist/hand								
Hip/thigh								
Knee								
Leg/ankle								
Foot								
Station based examination only								
CLEARANCE								
☐ Cleared								
☐ Cleared after completing evaluati	on/rehabilitation for:							
☐ Not Cleared for:	1	Reason:						
Recommendations:								
			D-4-					
Name of Physician (Print/Type)			Date					

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MD or DO

Signature of Physician_