Evangel Family Christian Academy

Pre-participation Physical Evaluation Form

History Date _____

Name_____ Sex _____ Age_____ Date of birth _____

Address_____Phone _____

School_____ Grade _____Sport _____

Explain "Yes" answers below:	Yes	No
1. Has a doctor ever restricted/denied your participation in sports?	☐	☐
2. Have you ever been hospitalized or spent a night in a hospital?	☐	☐
Have ever had surgery?	☐	☐
3. Do you have any ongoing medical conditions (like Diabetes or Asthma)?	☐	☐
4. Are you presently taking any medications or pills (prescription or over-the-counter?	☐	☐
5. Do you have any allergies (medicine, pollens, foods, bees or other stinging insects)?	☐	☐
6. Have you ever passed out during or after exercise?	☐	☐
Have you ever been dizzy during or after exercise?	☐	☐
Have you ever had chest pain or discomfort in your chest 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, high cholesterol, or heart infection?	☐	☐
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?	☐	☐
Does anyone in your family have a heart condition?	☐	☐
Has a doctor ever ordered a test on your heart (EKG, echocardiogram)?	☐	☐
7. Do you have any skin problems (itching, rashes, staph, MRSA, acne)?	☐	☐
8. Have you ever had a head injury or concussion?	☐	☐
Have you ever been knocked out or unconscious?	☐	☐
Have you ever had a seizure?	☐	☐
Have you ever had a stinger, burner, pinched nerve, or loss of feeling or weakness in your arms or legs?	☐	☐
9. Have you ever had heat or muscle cramps?	☐	☐
Have you ever been dizzy or passed out in the heat?	☐	☐
10. Do you have trouble breathing or do you cough during or after activity?	☐	☐
Do you take any medications for asthma (for instance, inhalers)?	☐	☐
11. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)?	☐	☐
12. Have you had any problems with your eyes or vision?	☐	☐
Do you wear glasses or contacts or protective eye wear?	☐	☐
13. Have you had any other medical problems (infectious mononucleosis, diabetes, infectious diseases, etc.)?	☐	☐
14. Have you had a medical problem or injury since your last evaluation?	☐	☐
15. Have you ever been told you have sickle cell trait?	☐	☐
Has anyone in your family had sickle cell disease or sickle cell trait?	☐	☐
16. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints? Head Back Shoulder Forearm Hand Hip Knee Ankle; Neck Chest Elbow Wrist Finger Thigh Shin Foot	☐	☐
17. When was your first menstrual period?		
When was your last menstrual period?		
What was the longest time between your periods last year?		
Explain "Yes" answers:		

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

Signature of athlete _____ Date _____

Signature of parent/guardian _____

DUPLICATE AS NEEDED

Preparticipation Physical Evaluation **Rule 1, Sec. 14** — In order for a student to be eligible for interscholastic athletics, there must be on file in the Superintendent's or Principal's office a current physician's statement certifying that the student has passed a physical exam, and that in the opinion of the examining physician (M.D. or D.O.) the student is fully able to participate in interscholastic athletics (Grade s 7-12). The AHSAA Physicians Certificate (Form 5) must be used. **A physical exam will satisfy the Physical Examination requirement for one calendar year from the date of the exam.**

	LIMITED	Height Weight BP _____ / _____ Pulse		
		Vision R 20 / ____ L 20 / ____ Corrected: Y N		
			Normal	Abnormal Findings
		Cardiovascular		
		Pulses		
		Heart		
		Lungs		
		Skin		
		E.N.T.		
		Abdominal		
		Genitalia (males)		
		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
☐ Noncontact ____ Strenuous ____ Moderately strenuous ____ Nonstrenuous

Due to: _____

Recommendation: _____

Name of physician _____ Date _____

Address _____ Phone _____

Signature of physician _____ , M.D. or D.O.