

ALABAMA HIGH SCHOOL ATHLETIC ASSOCIATION  
**Preparticipation Physical Evaluation**

DR

History \_\_\_\_\_ Date \_\_\_\_\_  
 Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_  
 School \_\_\_\_\_ Grade \_\_\_\_\_ Sport \_\_\_\_\_

Explain "Yes" answers below:

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 1. Have you ever been hospitalized? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had surgery? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you presently taking any medications or pills? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have any allergies (medicine, bees or other stinging insects)? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever passed out during or after exercise? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been dizzy during or after exercise? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had chest pain during or after exercise? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you tire more quickly than your friends during exercise? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had high blood pressure? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been told that you have a heart murmur? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had racing of your heart or skipped heartbeats? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Has anyone in your family died of heart problems or a sudden death before age 50? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any skin problems (itching, rashes, acne)? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever had a head injury? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been knocked out or unconscious? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a seizure? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a stinger, burner or pinched nerve? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had heat or muscle cramps? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been dizzy or passed out in the heat? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have trouble breathing or do you cough during or after activity? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you had any problems with your eyes or vision? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you wear glasses or contacts or protective eye wear? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you had any other medical problems (infectious mononucleosis, diabetes, etc.)? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you had a medical problem or injury since your last evaluation? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Head <input type="checkbox"/> Back <input type="checkbox"/> Shoulder <input type="checkbox"/> Forearm <input type="checkbox"/> Hand <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Ankle |                          |                          |
| <input type="checkbox"/> Neck <input type="checkbox"/> Chest <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Finger <input type="checkbox"/> Thigh <input type="checkbox"/> Shin <input type="checkbox"/> Foot  |                          |                          |
| 14. 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.

Date \_\_\_\_\_

Signature of athlete \_\_\_\_\_

Signature of parent/guardian \_\_\_\_\_

DUPLICATE AS NEEDED

Rule 1, Sec. 13 — No student shall be eligible to represent his/her school in interscholastic athletics unless there is on file in the Superintendent's or Principal's office a physician's statement for the current year certifying that the student has passed an adequate physical examination, and that in the opinion of the examining physician he/she is fully able to participate in high school athletics.

**Physical Examination**

COMPLETE	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.