**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 copy of this form in the chart.)

**Date of Exam**

Name

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
  - □ Pollen
  - □ Food
  - □ Stinging insects

**GENERAL QUESTIONS**

1. Has a doctor ever denied or restricted your participation in sports for any reason?
2. Do you have any ongoing medical conditions? If so, please identify below: □ Asthma □ Arthritis □ Diabetes □ Infections Other:
3. Have you ever spent the night in the hospital?
4. Have you ever had surgery?

**HEART HEALTH QUESTIONS ABOUT YOU**

5. Have you ever passed out or nearly passed out during or after exercise?
6. Have you ever had discomfot, pain, tightness, or pressure in your chest during exercise?
7. Does your heart beat 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 □ High cholesterol □ Heart murmur □ Heart infection
9. Has a doctor ever ordered a test for your heart? (for example, ECG, EKG, 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**

13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including crowding, unexplained car accident, or sudden infant death syndrome)?
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, amyloid, malignant ventricular tachycardia, long QT syndrome, short QT syndrome, Brugada syndromes, 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**

17. Have you ever had an injury to a bone, muscle, tendon, or joint 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, surgery, or cast?
20. Have you ever had a stress fracture?
21. Have you ever been told that you have or you had an x-ray for neck instability or to examine instability? (Down syndrome or dwarfism)
22. Do you regularly use a brace, orthotics, or another 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 hurt red?
25. Do you have any history of juvenile arthritis or connective tissue disease?

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 Orthopaedic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment.

Page 1 of 4
Preparticipation Physical Evaluation

The Athlete with Special Needs:
Supplemental History Form

Date of Exam ____________________________ Date of birth ____________________________

Name ____________________________ Sex __________ Age __________ Grade __________ School ____________________________ Sport(s) ____________________________

1. Type of disability ____________________________
2. Date of disability ____________________________
3. Classification (if available) ____________________________
4. Cause of disability (birth, disease, accident/trauma, other) ____________________________
5. List the sports you are interested in playing ____________________________

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Do you regularly use a brace, assistive device, or prosthesis?</td>
<td></td>
</tr>
<tr>
<td>7. Do you use any special brace or assistive device for sports?</td>
<td></td>
</tr>
<tr>
<td>8. Do you have any rash, pressure sores, or any other skin problems?</td>
<td></td>
</tr>
<tr>
<td>9. Do you have a hearing loss? Do you use a hearing aid?</td>
<td></td>
</tr>
<tr>
<td>10. Do you have a visual impairment?</td>
<td></td>
</tr>
<tr>
<td>11. Do you use any special devices for bowel or bladder function?</td>
<td></td>
</tr>
<tr>
<td>12. Do you have burning or discomfort when urinating?</td>
<td></td>
</tr>
<tr>
<td>13. Have you had anastomotic stricture?</td>
<td></td>
</tr>
<tr>
<td>14. Have you ever been diagnosed with a heart-related (hypertension) or cold-related (hypothermia) illness?</td>
<td></td>
</tr>
<tr>
<td>15. Do you have muscle spasticity?</td>
<td></td>
</tr>
<tr>
<td>16. Do you have frequent seizures that cannot be controlled by medication?</td>
<td></td>
</tr>
</tbody>
</table>

Explain "yes" answers here ____________________________

Please indicate if you have ever had any of the following:

<table>
<thead>
<tr>
<th>Ataxia/toward instability</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>X-ray evaluation for ataxia/toward instability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dislocated joints (more than one)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Easy bleeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epilepsy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epilepsy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Osteoporosis or osteopenia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty controlling bowel</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty controlling bladder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numbness or tingling in arms or hands</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numbness or tingling in legs or feet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weakness in arms or hands</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weakness in legs or feet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recent change in coordination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recent change in ability to walk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spina bifida</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Latax allergy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 ____________________________ Date ____________________________

Signature of parent/guardian ____________________________ Date ____________________________


New Jersey Department of Education 2014; Pursuant to P.L. 2013, c. 71.
### Preparticipation Physical Examination 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 feel safe at your house or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you chew tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?

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 R</th>
<th>Vision L</th>
<th>Corrected</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
</table>

### MEDICAL

- **Abnormal findings**
  - **Appearance**
    - Marfan syndrome, high arches, pectus excavatum, arachnodactyly, arm span > height, hypertelorism, myopia, MVP, aortic insufficiency
  - **Eyes/ears/nose/mouth**
    - Pupils equal
    - Hearing
  - **Lymph nodes**
    - *Note*
    - Mumps (parotid gland, submandibular, parotid node)
    - Location of point of maximal impulse (PMI)
  - **Pulses**
    - Simultaneous femoral and radial pulses
  - **Lungs**
  - **Abdomen**
  - **Genitalia (males only)**
  - **Skin**
    - HSV, lesions suggestive of MRSA, lice corporis
  - **Neurologic**

### MUSCULOSKELETAL

- **Neck**
- **Back**
- **Shoulder/arm**
- **Elbow/forearm**
- **Wrist/hand/finger**
- **Hip/thigh**
- **Knee**
- **Leg/ankle**
- **Foot/toe**
- **Functional**
  - Sit-to-stand, single-leg hop

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

*Consider MRI exam if private setting, having third party payor is recommended.

*Consider cognitive evaluation or brain scan to rule out 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 sport
  - [ ] For certain sport
  - [ ] Reason

**Recommendations**

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present any apparent contraindications to 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, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parent/guardian).

Name of physician, advanced practice nurse (APN), physician assistant (PA) (print/type): __________

Address: __________

Signature of physician, APN, PA: __________

Date of exam: __________

©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 Orthopaedic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment.

New Jersey Department of Education 2014; Pursuant to P.L.2010, c.71

For Doctor
Preparticipation Physical Evaluation

CLEARANCE FORM

Name ____________________________ Sex □ M □ F Age ____________ Date of birth ____________

☐ 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 _______________________________________________________

______________________________________________________________

EMERGENCY INFORMATION

Allergies ________________________________________________________________

______________________________________________________________

______________________________________________________________

Other information _______________________________________________________

______________________________________________________________

HCP OFFICE STAMP

SCHOOL PHYSICIAN:

Reviewed on __________________ (Date)

Approved ______ Not Approved ______

Signature: _______________________________________________________

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, advanced practice nurse (APN), physician assistant (PA) ____________________________ Date ____________

Address _____________________________________________________________ Phone ______

Signature of physician, APN, PA _______________________________________

Completed Cardiac Assessment Professional Development Module

Date __________________ Signature ________________________________


New Jersey Department of Education 2014; Pursuant to P.L. 2013, c.71

For Doctor