DESERT CHRISTIAN ACADEMY

Empowering the Mind, Engaging the Soul

Preparticipation Physical Evaluation

HISTORY

DATE OF EXAM__________________

Name____ Sex______ Age______ Date of birth_______________

Grade____ School____________________ Sports____

Address____ Phone__________________

Personal physician____

In case of emergency, contact

Name_______________________ Relationship_____________ Phone (H)_______________ (W)_______________

Explain "Yes" answers below.
Circle questions you don't know th e answers in.

	Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?	☐	☐
Do you have an ongoing or chronic illness?	☐	☐
2. Have you ever been hospitalized overnight?	☐	☐
Have you ever had surgery?	☐	☐
3. Are you currently tanking any prescription or nonprescription (over the counter medications) or pills or using an inhaler?	☐	☐
Have you ever taken any suppl ements or vitamins to help you gain or lose weight or improve your performance?	☐	☐
4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	☐	☐
Have you ever had a rash or hives develop during or after exercise?	☐	☐
5. Have you ever passed out during or after exercise?	☐	☐
Have you ever been dizzy during or after exercise?	☐	☐
Have you ever had chest pai n during or after exercise?	☐	☐
Do you get tired more quickly than your friends do during exercise?	☐	☐
Have you ever had racing of your heart or skipped heartbeats?	☐	☐
Have you had high blood pressure or high cholesterol?	☐	☐
Have you ever been told you have a heart murmur?	☐	☐
Has any family member died of heart problems or of sudden death before age 50?	☐	☐
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	☐	☐
Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	☐	☐
7. Have you ever had a head injury or concussion?	☐	☐
Have you ever been knocked out, become unconscious, or lost your memory?	☐	☐
Have you ever had a seizure?	☐	☐
Do you have frequent or severe headaches?	☐	☐
Have you ever had numbness or tingling in your arms, hands legs or feet?	☐	☐
Have you ever had a stinger, burn, or pinched nerve?	☐	☐
8. Have you ever become ill from exercising in the heat?	☐	☐
9. Do you cough, wheeze, or have trouble breathing during or after activity?	☐	☐
Do you have asthma?	☐	☐
Do you have seasonal allergies that require medical treatment?	☐	☐

	Yes	No
10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for exam ple knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	☐	☐
11. Have you had any problems with your eyes or vision?	☐	☐
Do you wear glasses, contacts or protective eyewear?	☐	☐
12. Have you ever had a sprain, strain or swelling after injury?	☐	☐
Have you broken or fractured any bones or dislocated any joints?	☐	☐
Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?	☐	☐

If yes, check appropriate box and explain below.

☐ Head	☐ Elbow	☐ Hip
☐ Neck	☐ Forearm	☐ Thigh
☐ Back	☐ Wrist	☐ Knee
☐ Chest	☐ Hand	☐ Shin/calf
☐ Shoulder	☐ Finger	☐ Ankle
☐ Upper arm		☐ Foot

	Yes	No
13. Do you want to weight more or less than you do now?	☐	☐
Do you loose weight regularly to meet weight requirements for your sport?	☐	☐
14. Do you feel stressed out?	☐	☐

15. Record the date of your most recent immunizations (shots) for:

Tetanus__________________ Measles__________________

Hepatitis B________________ Chickenpox________________

FEMALES ONLY

16. When was your first menstrual period?_____________________
When was your most recent menstrual period?_______________
How much time do you usually have from the start of one period to the start on another?____________________________
How many periods have you had in the last year?_____________
What was the longest time between in the last year___________

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________

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Preparticipation Physical Evaluation

PHYSICAL EXAMINATION

Name____ Date of birth_______________

Height________ Weight________ % Body fat (optional)_______ Pulse______ BP____/____ (____/____, ____/____)

Vision R 20/_____ L 20/_____ Corrected: Y N Pupils: Equal _____ Unequal ____

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 evaluation/rehabilitation for:____ ______

____

____

____

☐ Not Cleared for:__________________________ Reason:________________________________

Recommondations:____

____

____

____

Name of Physician (Print/Type)____ Date_______________

Address____ Phone______________

Signature of Physician____ MD or DO