SAPULPA PUBLIC SCHOOLS ATHLETIC DEPARTMENT

PRE-PARTICIPATION PHYSICAL EVALUATION

Make a copy for your records and email the original to the Sapulpa Athletic Department at

athletics@sapulpaps.org

STUDENT fills out this box BEFORE examination.

Student ID#_____________ Last Name__________________ First__________________ Middle______________

Date of Birth____________ Grade ☐12 ☐11 ☐10 ☐9 ☐8 ☐7 ☐6

Sport(s) you plan on competing in: ____

DO NOT WRITE IN THIS SECTION - PHYSICIAN OR NURSE USE ONLY

Height_____ **Weight**_____ **Pulse**_____**bpm** **BP**_____/_____ _____/_____ _____/_____

Initial Recheck (If Necessary)

Vision: R 20/_____ L 20/_____ Corrected: Y/N If Yes: Glasses Contacts **Pupils**: Equal Unequal

MEDICAL	**Normal**	**Abnormal Findings**
Appearance		
Eyes/Ears/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia (Males only)		
Skin		

Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		

Clearance:

( ) Cleared

( ) Cleared Pending:____

( ) Not cleared Due To:____

Name and Title of Examiner:____ Date____________________

Address and City: ____ Phone___________________

Signature of Examiner: ____

SAPULPA PUBLIC SCHOOL ATHLETIC DEPARTMENT

PRE-PARTICIPATION MEDICAL HISTORY AND PARENTAL CONSENT FORM

Name____Sex: ☐Male ☐Female Age _____ Date of Birth _________________

Grade _____ School ____ Sport(s) ____

I certify that the information below is correct to the best of my knowledge. I hereby give my informed consent for the above-mentioned student to participate in activities. I understand the risk of injury in athletic participation. If my son/daughter becomes ill or injured, necessary medical care can be instituted by team physicians, athletic trainer, coaches or other personnel properly trainer.

SIGNATURE of ATHLETE ____ DATE ___________________________

SIGNATURE of PARENT/GUARDIAN ____ DATE ___________________________

Email of Parent/Guardian ____ Phone ___________________________

Explain "Yes" answers at the end of Questionnaire.

	Question	Yes	No
1.	Have you had a medical illness or injury since your last checkup or sports physical?	☐	☐
2.	Do you have an ongoing or chronic illness?	☐	☐
3.	Have you ever been hospitalized overnight?	☐	☐
4.	Have you ever had surgery?	☐	☐
5.	Are you currently taking any prescriptions or non-prescription (OTC) medications or pills or using an inhaler?	☐	☐
6.	Do you have any allergies (i.e. medicine, food, pollen, or stinging insects)?	☐	☐
7.	Have you ever had a rash of hives develop during or after exercise?	☐	☐
8.	Have you ever passed out during or after exercise?	☐	☐
9.	Have you ever been dizzy during or after exercise?	☐	☐
10.	Have you ever had chest pain during or after exercise?	☐	☐
11.	Do you get tired more quickly than your friends do during exercise?	☐	☐
12.	Have you been diagnosed with Sickle Cell Trait?	☐	☐
13.	Have you ever had racing of your heart or skipped heartbeats?	☐	☐
14.	Have you had high blood pressure or high cholesterol?	☐	☐
15.	Have you ever been told you have a heart murmur?	☐	☐
16.	Has any family member or relative died of heart problems or sudden death before age 50?	☐	☐
17.	Have you had severe viral infection (i.e. mono-nucleosis or myocarditis) within the last year?	☐	☐
18.	Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐
19.	Do you have any current skin problems (i.e. itching, rashes, acne, warts, fungus, or blisters?	☐	☐
20.	Have you ever had a head injury or concussion?	☐	☐
21.	Have you ever been knocked out, become uncon-scious or lost your memory?	☐	☐
22.	Have you ever had a seizure?	☐	☐
23.	Do you have frequent or severe headaches?	☐	☐
24.	Have you ever had numbness or tingling in your	☐	☐
25.	Have you ever become ill from exercising in the heat?	☐	☐
26.	Do you cough or have trouble breathing during or after activity?	☐	☐
27.	Do you have asthma?	☐	☐
28.	Do you have seasonal allergies that require medical treatment?	☐	☐
29.	Have you had any problems with your eyes or vision?	☐	☐
30.	Do you wear glasses, contacts, or protective eyewear?	☐	☐
31.	Have you ever been diagnosed with an injury or removal of an Internal organ (i.e. liver, spleen, kidney, etc.)? If so when?	☐	☐
32.	Have you broken or fractured any bones or dislocated any joints?	☐	☐
33.	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	☐	☐
34.	Do you want to weigh more or less than you do now?	☐	☐
35.	Do you lose weight regularly to meet weight requirements for your sport?	☐	☐
36.	Do you feel stressed out?		

37. Record the date of your most recent immunization shots for (**do not** turn in a copy of shot record): tetanus, hepatitis, measles, chicken pox). Record Below

38. Explain "YES" answers here:

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