DeRuyter Central School
Pre-participation Physical Evaluation for Interscholastic Sports

Student Name _____ Grade _____ Date of Exam _____

Date of Birth _____ Sex_____ Sports _____

PART I
Health History: (Explain "yes" answers below)

1. Have you had a medical illness or injury since your last check up or sports physical?.....Yes No
2. Do you have an ongoing or chronic illness (such as diabetes, heart murmur, asthma or a bleeding disorder)?.....Yes No
3. Have you ever been hospitalized overnight?.....Yes No
4. Have you ever had surgery?.....Yes No
5. Are you currently taking any prescription or non-prescription medications? (ex. Insulin, inhaler or Epi-pen)……Yes No
6. Have you every broken any bones or dislocated any joints?.....Yes No
7. Are you allergic to anything? (Example: Food, Bee stings, Medication)……..Yes No
8. Have you lost use of a body part? (Eyes, ears, kidney, testicle, etc.)……Yes No

Explain _____

SINCE YOUR LAST PHYSICAL:

1. Have you passed out during or after exercise?.....Yes No
2. Have you been dizzy during or after exercise?.....Yes No
3. Have you ever had chest pain during or after exercise?.....Yes No
4. Have you ever had a racing heart or noticed skipped heart beats?.....Yes No
5. Have you ever had high blood pressure or high cholesterol?.....Yes No
6. Have you ever been told you have a heart murmur? Yes No Did you go for testing? Yes No
   When? _____ Where? _____ Result? _____
7. Has a physician ever denied or restricted your participation in sports for any heart problems?.....Yes No
8. Has any family member or relative died of heart problems or of a sudden death before the age of 50?.....Yes No
9. Have you had a severe viral infection (for example myocarditis or mononucleosis) within the last month?.....Yes No
10. Have you ever been told that you have an enlarge liver or spleen?.....Yes No
11. Have you ever been knocked out, become unconscious or lost your memory?.....Yes No
12. Have you had a head injury or a concussion?.....Yes No
13. Have you ever had a seizure?.....Yes No
14. Do you have frequent or severe headaches?.....Yes No
15. Have you ever had numbness or tingling in your arms, hands, legs or feet?.....Yes No
16. Do you cough, wheeze or have trouble breathing during or after activitiy?.....Yes No
17. Do you use any unusual protective or corrective equipment or devices?.....Yes No
18. Have you had any trouble with your eyes or vision?.....Yes No
19. Do you wear glasses, contacts or protective eyewear?.....Yes No
20. Ever had a sprain, strain or swelling after an injury?.....Yes No

Explain "yes" answers_____

_____

_____

LIST ALLERGIES: _____

_____
(include allergies to foods, medications, bees, etc. and type of reaction)

LIST MEDICATIONS: _____

Females only:
When was your last menstrual period? _____ Are periods monthly? _____

BOTH SIDES OF THIS FORM MUST BE COMPLETED IN ADDITION TO THE PHYSICAL FORM

PART II

1. The student named on the reverse side has my permission to receive a physical screening by the designated school health care provider, and permission to engage in all prescribed activities except as noted by me, my student's private health provider or the school's designated health care provider.
2. I accept that I am responsible for notifying the team coach and school nurse should an injury or serious illness occur within the year for which this form is valid
3. In the event I cannot be reached in an emergency, I hereby give my permission for the teacher or coach in charge to authorize hospitalization, treatment, anesthesia, medication, surgery or other medical treatment deemed necessary.
    - I have read and fully understand statements #1, #2 and #3.
    - I understand that if I wish my student's private provider to do the physical screening, I must have that provider complete the lower portion of this form and complete a DeRuyter Central School physical form.
    - I have answered all questions to the best of my knowledge.

SIGNATURES:

Student: _____ Parent: _____ Date: _____

Print: _____ _____

PART III

THIS SECTION MUST BE COMPLETED BY THE HEALTH CARE PROVIDER PERFORMING THE PHYSICAL EXAM

I have reviewed the information provided on the opposite side of this form and have completed a physical examination of the student. **(Please note a sports physical includes vision and hearing screenings, scoliosis screening and urinalysis.)**

CLEARANCE (Student Name) _____

- ❑ Cleared for all sports
- ❑ **Not** cleared for: ❑contact/collision ❑endurance ❑other (specify) _____

Recommendations (include any corrective devices or limitations):

_____

_____

_____

_____

Does the student need to carry any special medications with him or her to practices and sporting events? (example: Inhaler, Epi-pen, Insulin, etc.) (Circle One) Yes No

Name of Medication(s) (please include dosage and when medication is indicated)

_____

_____

_____

Signature of
Health Care Provider _____ Date:_____

Print Name _____ Phone Number _____

Address _____

BOTH SIDES OF THIS FORM MUST BE COMPLETED IN ADDITION TO THE PHYSICAL FORM