PHYSICIAN'S PHYSICAL EVALUATION

Last Name: ______________________________________ First Name: _______________________

Date of Birth: _____/______/______ Age: _______

Height:_______________ Weight: ________________ BP: _______/_______ Pulse: ________________

Vision: R20/ ________ L20/ ________ Corrected: ❑ Yes ❑ No Pupils (Circle) Equal / Unequal R>L L>R

	Check ✓ (if option given)	**Specific Findings:**
Marfan's syndrome stigmata	❑ Yes ❑ No	
Heart:		
Rhythm	❑ Regular ❑ Irregular	
Murmur (supine)	❑ Yes ❑ No	
Murmur (standing)	❑ Yes ❑ No	
	Normal (✓)	**Specific Findings:**
Lungs	❑	
Skin	❑	
Abdominal	❑	
Femoral Pulses	❑	
Genitalia/Hernia	❑	
Musculoskeletal:		
Neck	❑	
Shoulders	❑	
Elbows	❑	
Wrists	❑	
Hands	❑	
Back	❑	
Knees	❑	
Ankles	❑	
Feet	❑	
Other	❑	

Clearance:

❑ Cleared

❑ Cleared after completing evaluation/rehabilitation for: ____

❑ Not cleared due to: ____

Recommendation: ____

____

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____

I hereby certify that this athlete was examined by me. At that time, no physical condition was detected which would reasonably be anticipated to render this athlete physically unfit to engage in any sport, except those marked below:

Girls Sports: ❑ Basketball, ❑ Cheerleading, ❑ Cross Country, ❑ Golf, ❑ Gymnastics, ❑ Indoor Soccer, ❑ Soccer, ❑ Softball, ❑ Swimming, ❑ Tennis, ❑ Volleyball

Name of Physician: ___________________________________ Address: ____

Phone: ________-________-____________________ ext. __________ ____

Signature of Physician: ___________________________________ Date: _____/_____/______

(Based on recommendations developed by The American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopedic Society for Sports Medicine and American Osteopathic Academy of Sports Medicine.)

PRE PARTICIPATION PHYSICAL EVALUATION
COMMUNITY BAPTIST CHRISTIAN SCHOOL
5715 Miami St.; South Bend, IN 46614
574-291-3620

Last Name: ____

First Name: ____________________ Date: _____/_____/______

Date of Birth: _____/______/______ Grade Next Year: ________

Home Address: ____

Phone: ________-________-___________________ Sex: **Female**

City: ________________________ State: ______ Zip: _____________

Personal Physician: ____

Parent/Guardian: ____

Physician's Phone: ________-________-_________________________

HISTORY Explain "Yes" answers here. (additional space below) Yes No

1. Have you ever been hospitalized? ______________________________ ❑ ❑
2. Have you ever had surgery? ______________________________ ❑ ❑
3. Are you presently under a doctor's care? ______________________________ ❑ ❑
4. Are you presently taking any medications or pills? ______________________________ ❑ ❑
5. Do you have any allergies (medicine, bees or other stinging insects)? ______________________________ ❑ ❑
6. Have you ever passed out during or after exercise? ______________________________ ❑ ❑
7. Have you ever been dizzy during or after exercise? ______________________________ ❑ ❑
8. Have you ever had chest pain during or after exercise? ______________________________ ❑ ❑
9. Have you ever had high blood pressure? ______________________________ ❑ ❑
10. Have you ever been told that you have a heart murmur? ______________________________ ❑ ❑
11. Have you ever had racing of your heart or skipped heartbeats? ______________________________ ❑ ❑
12. Has anyone in your family died of heart problems or a sudden death before age 50? ______________________________ ❑ ❑
13. Do you have any skin problems (itching, rashes, acne)? ______________________________ ❑ ❑
14. Have you ever had a head injury? ______________________________ ❑ ❑
15. Have you ever been knocked out or unconscious? ______________________________ ❑ ❑
16. Have you ever had a seizure, "fit" or epilepsy? ______________________________ ❑ ❑
17. Have you ever had a stinger, burner or pinched nerve? ______________________________ ❑ ❑
18. Have you ever had heat cramps, heat illness or muscle cramps? ______________________________ ❑ ❑
19. Do you have trouble breathing, or do you cough during or after activity? ______________________________ ❑ ❑
20. Do you use any special equipment (pads, braces, neck rolls, eye guards, etc.)? ______________________________ ❑ ❑
21. Have you had any problems with your eyes or vision? ______________________________ ❑ ❑
22. Do you wear glasses or contacts or protective eye wear? ______________________________ ❑ ❑
23. Are you missing an eye, kidney or testicle? ______________________________ ❑ ❑
24. Have you had any other medical problems (infectious mononucleosis, diabetes, anemia. etc.)? ______________________________ ❑ ❑
25. Have you had a medical problem or injury since your last evaluation? ______________________________ ❑ ❑
26. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints? ❑ ❑
    ❑ Head ❑ Shoulder ❑ Thigh ❑ Neck ❑ Elbow ❑ Knee ❑ Foot
    ❑ Forearm ❑ Shin/calf ❑ Back ❑ Wrist ❑ Ankle ❑ Hip ❑ Hand
27. Will your menstrual period prohibit you from safely participating in sports? ❑ ❑

Explain "Yes" answers: ____

____

28. When was your last tetanus shot? _____/______

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: ________________________________