

PARTICIPATION PHYSICAL EVALUATION
PARENTS NEED TO BRING IMMUNIZATION RECORDS WITH THEM
TO THIS VISIT AND NEED TO BE WITH CHILDREN FOR THE WIAA
PHYSICALS AS THEY MAY NEED TO GIVE CONSENT FOR A
TETANUS BOOSTER!

(Medical History to be Retained by Physician/Provider)

Date of Exam _____

HISTORY

NAME (Last) _____ (First) _____ (Middle Initial) _____

DATE OF BIRTH _____ GRADE ____ AGE ____ SEX ____ SCHOOL _____

SPORT(S) _____

CITY _____ STATE ____ ZIP CODE _____ TELEPHONE _____

PERSONAL PHYSICIAN _____

Explain "Yes" answer(s) below. Circle questions you don't know the answers to.

- | | | |
|--|-----|----|
| 1. Have you had a medical illness or injury since your last checkup or sports physical? | Yes | No |
| Do you have an ongoing or chronic illness? | Yes | No |
| 2. Have you ever been hospitalized overnight? | Yes | No |
| Have you ever had surgery? | Yes | No |
| 3. Are you currently taking any prescription or nonprescription (over-the counter) medications or pills or using an inhaler? | Yes | No |
| Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? | Yes | No |
| 4. Do you have any allergies (for example, to pollen, medicine, food or stinging insects)? | Yes | No |
| Have you ever had a rash or hives develop during or after exercise? | Yes | No |
| 5. Have you ever passed out during or after exercise? | Yes | No |
| Have you ever been dizzy during or after exercise? | Yes | No |
| Have you ever had chest pain during or after exercise? | Yes | No |
| Do you get tired more quickly than your friends do during exercise? | Yes | No |
| Have you ever had racing of your heart or skipped heartbeats? | Yes | No |
| Have you had high blood pressure or high cholesterol? | Yes | No |
| Have you ever been told you have a heart murmur? | Yes | No |
| Has any family member or relative died of heart problems or of sudden death before age 50? | Yes | No |
| Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? | Yes | No |
| Has a physician ever denied or restricted your participation in sports for any heart problems? | Yes | No |
| 6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus or blisters)? | Yes | No |

7. Have you ever had a head injury or concussion? Yes No
 Have you ever been knocked out, become unconscious, or lost your memory? Yes No
 Have you ever had a seizure? Yes No
 Do you have frequent or severe headaches? Yes No
 Have you ever had numbness or tingling in your arms, hands, legs or feet? Yes No
 Have you ever had a stinger, burner or pinched nerve? Yes No
8. Have you ever become ill from exercising in the heat? Yes No
9. Do you cough, wheeze, or have trouble breathing during or after activity? Yes No
 Do you have asthma? Yes No
 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 example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? Yes No
11. Have you had any problems with your eyes or vision? Yes No
 Do you wear glasses, contacts or protective eyewear? Yes No
12. Have you ever had a sprain, strain or swelling after injury? Yes No
 Have you broken or fractured any bones or dislocated any joints? Yes No
 Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? Yes No
- If yes, circle appropriate area and explain below.
- | | | | | | | |
|-------|-----------|-------|------|-----------|----------|--------|
| Head | Elbow | Hip | Neck | Forearm | Thigh | Back |
| Wrist | Knee | Chest | Hand | Shin/Calf | Shoulder | Finger |
| Ankle | Upper arm | Foot | | | | |
13. Do you want to weigh more or less than you do now? Yes No
 Do you lose weight regularly to meet weight requirements for your sport? Yes No
14. Do you feel stressed out? Yes No
15. Record the dates of your most recent immunizations (shots) for:
 Tetanus _____ Measles _____ Hepatitis B _____ Chicken Pox _____

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 of another?

 How many periods have you had in the last year? _____
 What was the longest time between periods in the last year? _____

Explain "Yes" answer(s) 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 _____

