

■ PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Note: Complete and sign this form (with your pare	ents if younger tha			
Name:		D	ate of birth:	
Date of examination:	Sport	(s):		
Sex: M/F				
List past and current medical conditions.				
Have you ever had surgery? If yes, list all past sur	gical procedures.			
Medicines and supplements: List all current preso	riptions, over-the-	counter medicines, c	and supplements (herbal and n	utritional).
Do you have any allergies? If yes, please list all y	your allergies (ie, r	medicines, pollens, f	ood, stinging insects).	
Patient Health Questionnaire Version 4 (PHQ-4)				
Over the last 2 weeks, how often have you been	bothered by any o	of the following prob	olems? (check box next to appro	priate number)
Feeling nervous, anxious, or on edge		Several days	Over half the days Near	
Not being able to stop or control worrying			∐2 [_ 3
Little interest or pleasure in doing things	H			<u></u> 3
Feeling down, depressed, or hopeless		<u> </u>		<u>□</u> 3
(A sum of ≥3 is considered positive on either	□0 er subscale [auesti	ons 1 and 2 or aug	<u> </u>	□3
	ar oddoddio (docsiii	ons rana 2, or que	shorts 3 drid 4] for screening p	ourposes.)
GENERAL QUESTIONS		HEART HEALTH OL	ESTIONS ABOUT YOU	
(Explain "Yes" answers at the end of this form.		(CONTINUED)	ESTICINS ABOUT 100	Yes No
Circle questions if you don't know the answer.)	Yes No	9. Do you get lig	ht-headed or feel shorter of breath	arsa kalendarakka baratakasila
 Do you have any concerns that you would like to discuss with your provider? 		than your frie	nds during exercise?	
Has a provider ever denied or restricted your participation in sports for any reason?		10. Have you ever		
 Do you have any ongoing medical issues or recent illness? 		11. Has any family	ESTIONS ABOUT YOUR FAMILY y member or relative died of heart	Yes No
HEART HEALTH QUESTIONS ABOUT YOU	Yes No	problems or h	ad an unexpected or unexplained	
4. Have you ever passed out or nearly passed out during or after exercise?			before age 35 years (including nexplained car crash)?	
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		problem such	n your family have a genetic hear as hypertrophic cardiomyopathy	
Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		(HCM), Marfa ventricular car syndrome (LQ)		
7. Has a doctor ever told you that you have any heart problems?		Brugada syndr	IS), short QT syndrome (SQTS), rome, or catecholaminergic polycular tachycardia (CPVT)?	
 Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography. 		13. Has anyone in an implanted of	your family had a pacemaker or Jefibrillator before age 35?	



BOI	NE AND JOINT QUESTIONS	Yes	No	MEDICAL QUESTIONS (CONTINUED)	Yes	No
14.	Have you ever had a stress fracture or an injury			25. Do you worry about your weight?		
	to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?	Ш	Ш	Are you trying to or has anyone recommended that you gain or lose weight?		П
15.	Do you have a bone, muscle, ligament, or joint injury that bothers you?			27. Are you on a special diet or do you avoid certain types of foods or food groups?	П	П
MEI	DICAL QUESTIONS	Yes	No	28. Have you ever had an eating disorder?	Ħ	Ħ
16.	Do you cough, wheeze, or have difficulty breathing during or after exercise?			FEMALES ONLY	Yes	No
1 <i>7</i> .	Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?			29. Have you ever had a menstrual period? 30. How old were you when you had your first menstrual period?	Ш	
18.	Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		П	31. When was your most recent menstrual period?		
19.	Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?			32. How many periods have you had in the past 12 months? Explain "Yes" answers here.		
20.	Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?				10	
21.	Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?					
22.	Have you ever become ill while exercising in the heat?		П			
23.	Do you or does someone in your family have sickle cell trait or disease?					
24.	Have you ever had or do you have any prob- lems with your eyes or vision?					
Signat	eby state that, to the best of my known correct. Ure of athlete: Ure of parent or guardian:	wledg	je, my	answers to the questions on this form are co	mple	te
9 2010						

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Student-Athlete COVID Questionnaire

Student-Athlete's Name:		
Date of Birth:	Age:	

COVID RELATED QUESTIONS ABOUT THE STUDENT-ATHLETE	YES	NO	NA
Since January 1, 2020 have you been told that you have had a positive test for COVID-19, OR have you been told by a medical professional, your school, or local health department that you have had to quarantine (stay home) due to concern that you had COVID-19 symptoms?			
2. If the answer to 1 was "Yes", has the required Return to Play Form: COVID-19 Infection Medical Clearance Releasing The Student-Athlete to Resume Full Participation in Athletics been completed?			
3. Have you been fully vaccinated against COVID?			

■ PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

Name:	-	Do	ate of bir	th:		
PHYSICIAN REMINDERS						
1. Consider additional questions on more-sensitive i Do you feel stressed out or under a lot of pres Do you ever feel sad, hopeless, depressed, or Do you feel safe at your home or residence? Have you ever tried cigarettes, e-cigarettes, cl During the past 30 days, did you use chewing Do you drink alcohol or use any other drugs? Have you ever taken anabolic steroids or used Have you ever taken any supplements to help Do you wear a seat belt, use a helmet, and us Consider reviewing questions on cardiovascular seasons.	sure? canxious? hewing tobacco, snuff, or dip g tobacco, snuff, or dip? d any other performance-enl you gain or lose weight or in se condoms?	nancing supplement mprove your perfo	nt?			
EXAMINATION				* 15		
Height: Weight:	The same of the sa		Property Comments of the state of		ANTONIO PARENTALIS	er and a second and
BP: / (/) Pulse:	Vision: R 20/	L 20/	Correc	ted:	ΥC	N
MEDICAL				NORM	AL	ABNORMAL FINDINGS
Appearance Marfan stigmata (kyphoscoliosis, high-arched palmyopia, mitral valve prolapse [MVP], and aortic i	ate, pectus excavatum, aracl nsufficiency)	nnodactyly, hyperl	axity,			
Eyes, ears, nose, and throat Pupils equal Hearing						
Lymph nodes						
Heart ^o			-	느느		
Murmurs (auscultation standing, auscultation supir	ne. and ± Valsalva maneuve	-1				
Lungs	·		-	==	\dashv	
Abdomen	700				\vdash	
Skin Herpes simplex virus (HSV), lesions suggestive of r tinea corporis	nethicillin-resistant Staphyloc	occus aureus (MR	SA), or			
Neurological			-			
MUSCULOSKELETAL			10 m	NORM	AL	ABNORMAL FINDINGS
Neck .						
Back		19				
Shoulder and arm						
Elbow and forearm						
Wrist, hand, and fingers						
Hip and thigh						
Knee						1.00
Leg and ankle						
Foot and toes Functional						
Double-leg squat test, single-leg squat test, and bo	x drop or step drop test					
 Consider electrocardiography (ECG), echocardiograp nation of those. 	hy, referral to a cardiologist		diac histor	y or exa	minat	ion findings, or a combi-
Name of health care professional (print or type):					Date:	
Addross:			Pho	 one:		
Signature of health care professional:				200-169010 50		, MD, DO, NP, or PA

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NGHSAA Approved for Use Beginning March 2021

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MEDICAL FLIGIRILITY FORM

Name:	Date of hirth:	
Medically eligible for all sports without restriction	Date of billin.	-
Medically eligible for all sports without restriction with recommendations for furth	er evaluation or treatment of	
☐ Medically eligible for certain sports		-
□ Not medically eligible pending further evaluation		-
□ Not medically eligible for any sports Recommendations:		. .
I have examined the student named on this form and completed the preparapparent clinical contraindications to practice and can participate in the spexamination findings are on record in my office and can be made available arise after the athlete has been cleared for participation, the physician may and the potential consequences are completely explained to the athlete (and	oort(s) as outlined on this form. A copy of le to the school at the request of the paren y rescind the medical eligibility until the pr	the physical its If conditions
Name of health care professional (print or type):		
Address:	Phone:	
Signature of health care professional:		
SHARED EMERGENCY INFORMATION		
Allergies:		
		-
Medications:	j.	- -
		<u> </u>
Other information:		-
Emergency contacts:		=
		-
		_

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