PRE-PARTICIPATION PHYSICAL EVALUATION
2023-2024 SCHOOL YEAR

To be completed by the Parent for School:

STUDENT NAME: _____ DOB: _____ AGE: _____ GENDER: _____

HOME ADDRESS: _____

SCHOOL: _____ GRADE: _____ SPORT(s): _____

FATHER/GUARDIAN NAME: _____

EMAIL: _____

CELL PHONE: _____

FATHER'S EMPLOYER: _____

WORK PHONE: _____

MOTHER/GUARDIAN NAME: _____

EMAIL: _____

CELL PHONE: _____

MOTHER'S EMPLOYER: _____

WORK PHONE: _____

EMERGENCY CONTACTS

NAME: _____	NAME: _____
PHONE: _____	PHONE: _____
EMAIL: _____	EMAIL: _____
RELATIONSHIP: _____	RELATIONSHIP: _____

PHYSICIAN NAME: _____ PHONE: _____

INSURANCE PROVIDER: _____ POLICY NUMBER: _____

NAME OF INSURED: _____ GROUP NUMBER: _____

MEDICINES: List all prescription, over the counter, and supplements student is currently taking: _____

_____

Parental Consent

I grant permission for my child to participate in extracurricular athletic activities. These activities will take place under the guidance and direction of school employees and/or volunteers. As a parent and/or legal guardian, I remain legally responsible for personal actions taken by my participating child I agree on behalf of myself, my participating child, our heirs, successors and assigns, to hold harmless and defend the school, its employees, officers, directors and agents, and the Archdiocese of Galveston-Houston, or representatives associated with these activities, arising from our in connection with my child participating in these activities, or in connection with any illness, injury or cost of medical treatment in connection therewith, and I agree to compensate the school, its officers, directors and agents, and the Archdiocese of Galveston-Houston, or representatives associated with the activity for reasonable attorney's fees or expenses arising in connection therewith. I hereby warrant to the best of my knowledge, that my child is in good health, and I assume all responsibility for the health and medical care of my child. In the event of a medical emergency, I hereby give permission to school employees and/or volunteers supervising the athletic event to obtain medical services and to transport my child to the nearest hospital/emergency care center for emergency medical or surgical treatment.

Parent/Guardian Signature: _____ Date: _____

PRE-PARTICIPATION PHYSICAL EVALUATION
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To be completed by the Physician/Licensed Examiner for School:

STUDENT NAME: _____ DATE OF BIRTH: _____ AGE: _____

EXAMINATION

Height:_____ Weight: _____ Pulse:_____ Blood Pressure: _____/_____

Vision R 20/_____L 20/_____ Corrected: Yes_____ No_____ Pupils: Equal _____ Unequal _____

Hearing: Normal_____ Referred_____ Spinal Exam: Normal_____Referred_____ % Body Fat (optional)_____

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
Eyes/ears/nose/throat		
Lymph nodes		
Heart-Auscultation of the heart in the **supine** position		
Heart-Auscultation of the heart in the **standing** position		
Heart-lower extremity pulses		
Pulses		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination forms signed by any other health care practitioner, will not be accepted.

CLEARANCE

- ☐ Cleared for all sports without restriction
- ☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for: _____
- ☐ Not cleared
  - ☐ Pending further evaluation
  - ☐ For any sport
  - ☐ For certain sports:

  Reason: _____

  Recommendations: _____

Physician/Clinician Signature: _____

Physician/Clinician Print Name: _____

Address:_____

Phone: _____ **Date of Exam**: _____

PRE-PARTICIPATION PHYSICAL EVALUATION
2023-2024 SCHOOL YEAR

To be completed by the Parent for Healthcare Provider:

DIRECTIONS: Complete questions below and explain "YES" answers in the space provided.

GENERAL QUESTIONS	YES	NO	UNSURE
1. Has your doctor ever denied or restricted your participation in sports for any reason?			
2. Do you have any ongoing medical conditions? If so check all that apply: □ Asthma □ Anemia □ Diabetes □ Infections □ Other:_____			
3. Have you ever spent the night in the hospital in the past year?			
4. Have you ever had surgery?			
HEART HEALTH QUESTIONS	**YES**	**NO**	**UNSURE**
5. Have you ever passed out or nearly passed out during or after exercise?			
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			
7. Does your heart ever race or skip beats (irregular beats) during exercise?			
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: □ High blood pressure □ High cholesterol □ Kawasaki disease □ A heart murmur □ A heart infection □ Other: _____			
9. Do you get lightheaded or feel more short of breath than expected during exercise?			
10. Have you ever had an unexplained seizure?			
11. Do you get more tired or short of breath more quickly than your friends during exercise?			
FAMILY HEART HEALTH QUESTIONS	**YES**	**NO**	**UNSURE**
12. Has any family member or relative died of heart problems or unexpected sudden death before age 50?			
13. Has any family member been diagnosed with a heart condition?			
BONE AND JOINT QUESTIONS	**YES**	**NO**	**UNSURE**
14. Have you had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or game?			
15. Have you had any fractured bones or dislocated joints?			
16. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast?			
17. Do you regularly use a brace, orthotics or other assistive device?			
18. Do any of your joints become painful, swollen, feel warm or look red?			
MEDICAL QUESTIONS	**YES**	**NO**	**UNSURE**
19. Do you cough, wheeze, or have difficulty breathing during or after exercise?			
20. Do you have any allergies? If so, check all that apply: □ Pollen □ Medicine □ Food □ Stinging Insects □ Other: _____			
21. Are you missing any paired organs?			
22. Have you had a severe viral infection (myocarditis, mononucleosis, etc.) in the past year?			
23. Do you currently have any skin problems (itching, acne, warts, fungus, or blisters)?			
24. Have you ever had a head injury or concussion?			
25. Have you ever been knocked unconscious or lost memory?			
26. Do you have a history of seizure disorder?			
27. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?			
28. Have you ever become ill while exercising in the heat?			
29. Have you been diagnosed with or treated for Sickle Cell Trait or Sickle Cell Disease?			
30. Have you had any problems with your eyes or vision?			
31. Have you ever had unexpected shortness of breath with exercise?			
32. Have you had any eye injuries?			
33. Do you use any special protective or corrective equipment?			
34. Do you lose weight regularly to meet weight requirements for an extra-curricular activity?			
35. Are you on a special diet or do you avoid certain foods?			
36. Have you ever had an eating disorder?			
37. Are you presently under a doctor's care?			
38. Do you have any concerns you would like to discuss with a doctor?			
FEMALES ONLY			
39. What year was your first menstrual cycle?			
40. What month and day was your most recent menstrual cycle?			
41. How many cycles have you had in the last 12 months?			
COVID-19 MEDICAL QUESTIONS			
42. Have you been diagnosed with COVID-19 at any time?			
43. Have you been hospitalized at any time due to COVID-19?			