

# MERIDIAN PRE-PARTICIPATION SPORTS PHYSICAL EXAM

Required for participation

**NAME:** \_\_\_\_\_ **BIRTH DATE:** \_\_\_\_\_ **EXAM DATE:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_

**Parent/Guardian Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Cell#:** \_\_\_\_\_

**In case of emergency contact: Name** \_\_\_\_\_ **Phone:** \_\_\_\_\_

\_\_\_\_\_ **Pre-Participation Exam**

\_\_\_\_\_ **Returning Exam**

**Yes/ No HISTORY (to be completed by student & parents)**

- Y N 1. Have you had any illness/injury recently or now?
- Y N 2. Have you had a medical problem, illness or injury since your last exam?
- Y N 3. Do you have any chronic or recurrent illness?
- Y N 4. Have you ever had an illness lasting more than a week?
- Y N 5. Have you ever been hospitalized overnight?
- Y N 6. Have you had any surgery?
- Y N 7. Have you ever had any injuries requiring treatment by a physician?
- Y N 8. Do you have any organ missing (appendix, eye, kidney, testicle, etc)?
- Y N 9. Are you presently taking any medications? (including vitamins, aspirin)
- Y N 10. Do you have **Any** allergies? (medicine, bees, foods)
- Y N 11. Have you ever had chest pain, dizziness, fainting, or passing out during or after exercise?
- Y N 12. Do you tire more easily or quickly than your friends during exercise?
- Y N 13. Have you ever had any problem with your blood pressure or your heart?
- Y N 14. Have any close relatives had heart problems, heart attacks, or sudden death before they were age 50?
- Y N 15. Do you have any skin problems (acne, itching, rashes, etc?)
- Y N 16. Have you ever had fainting, convulsions, seizures or severe dizziness?
- Y N 17. Do you have frequent severe headaches?
- Y N 18. Have you ever had a "stinger" or "burner" or "pinched nerve"?
- Y N 19. Have you ever been "knocked out" or "passed out"?
- Y N 20. Have you ever had a neck or head injury?
- Y N 21. Have you ever had heat exhaustion, heat stroke, heat cramps, or similar heat-related problems?"
- Y N 22. Do you have asthma, trouble breathing, or cough during/after exercise?
- Y N 23. Do you wear eyeglasses, contact lenses, or protective eyewear?
- Y N 24. Have you had any problem with your eyes or vision?
- Y N 25. Do you wear a dental appliance such as braces, bridge, plate, retainer?
- Y N 26. Have you ever had a knee or ankle injury?
- Y N 27. Have you ever injured any other joint (shoulder, wrist, fingers, etc.)?
- Y N 28. Have you ever had a broken bone (fracture)?
- Y N 29. Have you ever had a cast, splint, or had to use crutches?
- Y N 30. Must you use special equipment for competition (braces, etc.) ?
- Y N 31. Has it been more than 8 years since your last tetanus booster shot?
- Y N 32. Are you worried about your weight?
- Y N 33. Have you any medical concerns about participating in your sport?
- Y N 34. Are you taking any pills or drugs to increase your strength or performance?

**FEMALES ONLY:** When was your first menstrual period? \_\_\_\_\_  
 When was your last menstrual period? \_\_\_\_\_  
 How far apart are your periods? \_\_\_\_\_ How long do they last? \_\_\_\_\_  
 How many periods have you had in the last year? \_\_\_\_\_

**Explain "Yes" Answers to any of the above questions:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I attest, by my signature below, that to the best of my knowledge, my answers to the above questions are complete and correct.

**Signature of athlete:** \_\_\_\_\_

**Signature of parent:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PHYSICAL ( to be completed by doctor)**

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

BP : \_\_\_\_\_ Pulse: \_\_\_\_\_ Vision: R / L /

**MEDICAL**

| Normal/ Abnormal           | Findings |
|----------------------------|----------|
| N A Appearance             | _____    |
| N A Eyes                   | _____    |
| N A Ears                   | _____    |
| N A Nose                   | _____    |
| N A Throat                 | _____    |
| N A Lymph Nodes            | _____    |
| N A Heart                  | _____    |
| N A Pulses                 | _____    |
| N A Lungs                  | _____    |
| N A Abdomen                | _____    |
| N A Skin                   | _____    |
| N A Genitalia (males only) | _____    |

**MUSCULOSKELETAL**

| Normal /Abnormal    | Findings |
|---------------------|----------|
| N A Neck            | _____    |
| N A Back            | _____    |
| N A Shoulder / arm  | _____    |
| N A Elbow / forearm | _____    |
| N A Wrist / hand    | _____    |
| N A Hip / thigh     | _____    |
| N A Knee            | _____    |
| N A Leg / Ankle     | _____    |
| N A Foot            | _____    |

**ASSESSMENT:**

\_\_\_ **Full Participation** \_\_\_ **Limited Participation**

**Describe limitations/restrictions** \_\_\_\_\_  
 \_\_\_\_\_

**Participation contraindicated reasons** \_\_\_\_\_  
 \_\_\_\_\_

**Recommendations (equipment, taping, rehabilitation, referral)** \_\_\_\_\_  
 \_\_\_\_\_

\* **EXAMINER'S NAME** \_\_\_\_\_

\* **SIGNATURE:** \_\_\_\_\_

\* **PHONE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_