**General Instructions**

Prior to participation in any tryout, practice, scrimmage, competition or conditioning program, involving a team-sport, athletes must undergo a physical examination administered or supervised by a physician. The examination must be administered within six months prior to the start of the athlete's participation. Athletes have an obligation to disclose any medical condition and/or injury that as occurred since this physical examination prior to participation.

**Notice to Physicians:**

This document is provided as a screening tool to guide your assessment of the athlete's fitness for athletic competition. This form is recommended by the National Collegiate Athletic Association and was developed by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and the American Osteopathic Academy of Sports Medicine. For more information please see Wappes, James R., Ed., Pre-participation Physical Evaluation (McGraw-Hill, 2005, 3rd edition).

The examination of the athlete may be performed by a Physician Assistant, Certified Registered Nurse Practitioner, or other medical professional, under the approval and supervision of a licensed medical physician, where permitted by law. This form must be approved and signed by a licensed medical physician. PLEASE PUT PHYSICIAN LICENSE # BY SIGNATURE ON FINAL PAGE (CLEARANCE FORM).

**Notice to Athletes**

TEAM-SPORTS ATHLETICS- This form MUST be completed and submitted to NATALIE MECKSTROTH MA. ATC, Women's Basketball Office, 146 Bryce Jordan Center, University Park, PA 16802. Please return this form at least 2 weeks prior to participation.

Direct any questions to Natalie via. 814-863-3435

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**Team-Sports Office Use Only**

Received by: ___________________________ Date received: ___________________________

History Form __  Physical Examination Form __  Clearance Form __  Ok to file __
**Preparticipation Physical Evaluation**

**HISTORY FORM**

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam _______________________________ Date of birth _______________________________

Sex ___________________________ Age _______ Grade _______ School ___________________________ Sports(s) ___________________________

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Frequency</th>
<th>Allergy Type</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Do you have any allergies? [ ] Yes  [ ] No  [ ] If yes, please identify specific allergy below.  
[ ] Medicines [ ] Pollens [ ] Food [ ] Stinging Insects

Explain *"Yes"* answers below. Circle questions you don't know the answers to.

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### GENERAL QUESTIONS

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Has a doctor ever denied or restricted your participation in sports for any reason?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Do you have any ongoing medical conditions? [ ] Yes  [ ] No  If yes, please identify below: [ ] Asthma  [ ] Anemia  [ ] Diabetes  [ ] Infections  [ ] Other:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Have you ever spent the night in the hospital?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Have you ever had surgery?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### HEART HEALTH QUESTIONS ABOUT YOU

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Have you ever passed out or nearly passed out during or after exercise?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Does your heart ever race or skip beats (irregular beats) during exercise?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: [ ] High blood pressure  [ ] A heart murmur  [ ] High cholesterol  [ ] A heart infection  [ ] Kawasaki disease  [ ] Other:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Has a doctor ever tested for your heart? (For example, ECG/EKG, echocardiogram)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Do you get lightheaded or feel more short of breath than expected during exercise?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Have you ever had an unexplained seizure?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Do you get more tired or short of breath more quickly than your friends during exercise?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### HEART HEALTH QUESTIONS ABOUT YOUR FAMILY

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, ankylosing spondylitis, ventricular arrhythmia, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Has anyone in your family had an unexplained fainting, unexplained seizures, or near drowning?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### BONE AND JOINT QUESTIONS

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Have you ever had any broken or fractured bones or dislocated joints?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Have you ever had a stress fracture?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Have you ever been told that you have or you have had an x-ray for neck instability or atlantoaxial instability? (Giovanni syndrome or densitis)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Do you regularly use a brace, orthotics, or other assistive device?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Do you have a bone, muscle, or joint injury that bothers you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. Do any of your joints become painful, swollen, feel warm, or look red?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. Do you have any history of juvenile arthritis or connective tissue disease?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete: ___________________________ Date: ___________________________

Signature of parent/guardian: ___________________________ Date: ___________________________

PREPARTICIPATION PHYSICAL EVALUATION
THE ATHLETE WITH SPECIAL NEEDS:
SUPPLEMENTAL HISTORY FORM

Date of Exam
Name
Sex
Age
Grade
School
Sport(s)
Date of birth

1. Type of disability
2. Date of disability
3. Classification (if available)
4. Cause of disability (birth, disease, accident/trauma, other)
5. List the sports you are interested in playing

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>
6. Do you regularly use a brace, assistive device, or prosthesis? |
7. Do you use any special brace or assistive device for sports? |
8. Do you have any bruises, pressure sores, or any other skin problems? |
9. Do you have a hearing loss? Do you use a hearing aid? |
10. Do you have a visual impairment? |
11. Do you use any special devices for bowel or bladder function? |
12. Do you have burning or discomfort when urinating? |
13. Have you had autonomic dysreflexia? |
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness? |
15. Do you have muscle spasticity? |
16. Do you have frequent seizures that cannot be controlled by medication? |

Explain "yes" answers here

Please indicate if you have ever had any of the following.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>
Atlantoaxial instability |
X-ray evaluation for atlantoaxial instability |
Dislocated joints (more than one) |
Easy bleeding |
Enlarged spleen |
Hepatitis |
Osteopenia or osteoporosis |
Difficulty controlling bowel |
Difficulty controlling bladder |
Numbness or tingling in arms or hands |
Numbness or tingling in legs or feet |
Weakness in arms or hands |
Weakness in legs or feet |
Recent change in coordination |
Recent change in ability to walk |
Spina bifida |
Latex allergy |

Explain "yes" answers 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: ___________

# Preparticipation Physical Evaluation

## Physical Examination Form

**Name**  
**Date of birth**

### Physician Reminders

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried nicotine, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you chew tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any medications to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?

2. Consider reviewing questions on cardiovascular symptoms (questions 5-14).

### Examination

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>155cm</td>
<td>70kg</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### BP

- **Systolic**
- **Diastolic**
- **Pulse**

#### Vision

- **Vision R 20/20**
- **Vision L 20/20**
- **Corrected**

#### Medical

<table>
<thead>
<tr>
<th>Appearance</th>
<th>Normal</th>
<th>Abnormal Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Eyes/ears/nose/throat

- **Pupils equal**
- **Hearing**

#### Lymph nodes

#### Heart

- **Murmurs (auscultation standing, supine, +/- Valsalva)**
- **Location of point of maximal impulse (PMD)**

#### Pulses

- **Simultaneous femoral and radial pulses**

#### Lung

#### Abdomen

#### Genitourinary (males only)*

#### Skin

- **HSV lesions suggestive of MRSA, linea corporis**

#### Neurologic*

#### Musculoskeletal

#### Neck

#### Back

#### Shoulder/arm

#### Elbow/forearm

#### Wrist/hand/fingers

#### Hip/thigh

#### Knee

#### Leg/ankle

#### Foot/fees

#### Functional

- **Backwalk, single leg hop**

*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
*Consider GU exam if in pubertal setting. Having third party present is recommended.
*Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

- [ ] 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 sports
  - [ ] For certain sports

Reason

Recommendations

---

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete and (parents/guardians).

<table>
<thead>
<tr>
<th>Name of physician (print/type)</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>Phone</td>
</tr>
<tr>
<td>Signature of physician</td>
<td>MD or DO</td>
</tr>
</tbody>
</table>


H0073

9-25-01/0110
Preparticipation Physical Evaluation

Clearance Form

Name _______________________________  Sex ☐ M ☐ F  Age ___________  Date of birth ___________

☐ 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 sports

☐ For certain sports

Reason _______________________________

Recommendations _______________________________

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _______________________________  Date ___________

Address _______________________________  Phone _______________________________

Signature of physician _______________________________  MD or DO ___________

Emergency Information

Allergies _______________________________

Other Information _______________________________