

Cecil County Public Schools Interscholastic Athletics

Pre-Participation Physical Evaluation

HISTORY

To be completed by parent or guardian and submitted to the examining physician before the student is examined.

Name: _____	Sex: M / F	Age: _____	Date of Birth: _____
Grade: _____	School: _____	Parent's Name: _____	
Address: _____		Phone: _____	
Personal Physician: _____		Phone: _____	
In case of emergency, contact: Name: _____		Relationship: _____	
Home Phone: _____	Work Phone: _____	Other: _____	

DIRECTIONS: Please check box for "Yes" or "No" and explain "Yes" answers in the space below.

		YES	NO			YES	NO
1. Have you ever had a medical illness or injury since your last check up or sports physical?				22. Have you ever become ill from exercising in the heat?			
2. Have you ever been hospitalized overnight?				23. Do you cough, wheeze, or have trouble breathing during or after activity?			
3. Are you currently taking a prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?				24. Do you have asthma?			
4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?				25. Do you have seasonal allergies that require medical treatment?			
5. Have you ever passed out during or after exercise?				26. Do you have diabetes?			
6. Have you ever been dizzy during or after exercise?				27. Do you use insulin?			
7. Have you ever had chest pain during or after exercise?				28. Do you have any communicable diseases?			
8. Do you get tired more quickly than your friends do during exercise?				29. 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)?			
9. Have you ever had racing of your heart or skipped heartbeats?				30. Have you ever had any problems with your eyes or vision?			
10. Have you had high blood pressure or high cholesterol?				31. Do you wear glasses, contacts or protective eyewear?			
11. Have you ever been told you have a heart murmur?				32. Have you ever had a sprain, strain, or swelling after injury?			
12. Has any family member or relative died of heart problems or of sudden death before age 50?				33. Have you broken or fractured any bones or dislocated any joints?			
13. Have you had a severe viral infection (for example: myocarditis or mononucleosis) within the last month?				34. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? If "Yes", circle appropriate area and explain below:			
14. Has a physician ever denied or restricted your participation in sports for any heart problems?				Head	Elbow	Hip	
15. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?				Neck	Forearm	Thigh	
16. Have you ever had a head injury or concussion?				Back	Wrist	Knee	
17. Have you ever been knocked out, become unconscious, or lost your memory?				Chest	Hand	Shin/Calf	
18. Have you ever had a seizure?				Shoulder	Finger	Ankle	
19. Do you have frequent or severe headaches?				Upper Arm		Foot	
20. Have you ever had numbness or tingling in your arms, hands, legs, or feet?				35. Do you want to weigh more or less than you do now?			
21. Have you ever had a stinger, burner, or pinched nerve?				36. Do you lose weight regularly to meet weight			
				37. Do you feel stressed out?			

Explain "Yes" answers here: (attach additional sheet if necessary)

By signing below, I understand and agree that student athletes are not to use tobacco, alcohol, or other drugs at any time. (Reference: Interscholastic Rules & Regulations Handbook, 41.01)

Any substantiated reported use of alcohol, tobacco, or other drugs in school or out of school will be handled in accordance to county policy and will result in the automatic suspension of my child from the team for the remainder of the season.

I also hereby state that to the best of my knowledge, my answers to the above questions are complete and correct. I give my consent for the above named student to engage in interscholastic sports activities as a representative of their school except those activities crossed out by the examining physician on the reverse side of this form.

Signature of Athlete/Student

Date

Signature of Parent/Guardian

Read above paragraph before signing consent form.

**Pre-Participation Physical Evaluation
PHYSICAL EXAMINATION**

Date of examination: _____
 Name: _____ Date of Birth: _____
 Height: _____ Weight: _____ Pulse: _____ BP: _____
 Vision: R 20/ _____ L 20/ _____ Corrected: Y N Pupils: Equal _____ Unequal _____

*Certified Wrestling Minimum Weight: _____
 90% OF ABOVE WEIGHT*

Physician's Signature: _____

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			

MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS	INITIALS
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

CLEARANCE:

I have on this date, personally examined this pupil, reviewed the history and other data recorded on both sides of this form. I find this student physically able to compete in the interscholastic sports listed below which are NOT crossed out.

Basketball Cheerleading Field Hockey Football Golf Lacrosse Soccer
 Baseball Softball Tennis Track & Field Volleyball Wrestling Cross Country

This student is physically able to work in the "Construction Field" at the School of Technology (circle) Yes No

Not cleared for: _____ Reason: _____

Recommendations:

Name of physician (print/type): _____ Date: _____

Address: _____ Phone: _____

Signature of physician: _____ MD or DO

TO BE SIGNED BY PARENT AFTER THE PHYSICAL IS COMPLETED:

I have on this date reviewed the data recorded on both sides of this form.

Signature of parent: _____ Date: _____