CALVARY CHAPEL CHRISTIAN SCHOOL

Pre-Participation Physical Evaluation

Name:____Date of Birth:___/___/______

To Be Completed by Physician
Height:___________Weight:___________ Pulse:____________BP:_____________________
Vision: R 20/_______L 20/_______Corrected: (Circle) Y N Pupils: Equal_______Unequal_______

Medical	Normal	Abnormal Findings	Initials
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Musculoskeletal			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
Foot			

*Station-based examination only

CLEARANCE
Cleared______

Cleared after completing evaluation/rehabilitation for:_______________________________________
____

Not cleared for:_____________________________Reason:______________________________________
____
____

Recommendations:____
____
____

Name of Physician (print/type):_________________________________Phone:(____)____________
Address:____
Signature of Physician:____Date:________________

Pre-Participation Physical Evaluation

To Be Completed by Parent/Athlete

Name:____Sex:____Age:_____Date of Birth:____/____/_______

Grade:______School:___________________________________Sport(s):_____________________________________

Address:____Phone:(________)____________________

Personal Physician:____

In Case of Emergency, contact:

Name:___________________________Relationship:__________________Phone:(________)___________________H

Explain "Yes" answers below. Circle questions if not sure.

	Yes	No
1. Have you had a medical illness or injury since your last checkup or sports physical?	______	______
2. Have you ever been hospitalized overnight?	______	______
Have you ever had surgery?	______	______
3. Are you currently taking any pre-scription, non-prescription (over-the-counter) medication, or using an inhaler?	______	______
Have you ever taken any supplements or vitamins to help you to gain or lose weight or to improve your performance?	______	______
4. Do you have any allergies (e.g., to pollen, medicines, food, or stinging insects)?	______	______
Have you ever had a rash or hives develop during or after exercise?	______	______
5. Have you ever passed out during or after exercise?	______	______
Have you ever been dizzy during or after exercise?	______	______
Have you ever had chest pain during or after exercise?	______	______
Do you get tired more quickly than your friends during exercise?	______	______
Have you ever had racing of your heart or skipped heartbeats?	______	______
Have you had high blood pressure or high cholesterol?	______	______
Have you ever been told you have a heart murmur?	______	______
Have any family members or relatives died of heart problems or sudden death before age 80?	______	______
Have you had a severe viral infection (e.g., myocarditis or mononucleosis) within the last month?	______	______
Has a physician ever denied or restricted your participation in sports for any heart problems?	______	______
6. Do you have any current skin problems (e.g., itching, rashes, acne, warts, fungus, or blisters)?	______	______
7. Have you ever had a head injury or concussion?	______	______
Have you ever been knocked out, unconscious, or lost your memory?	______	______
Have you ever had a seizure?	______	______
Do you have frequent or severe headaches?	______	______
Have you ever had numbness or tingling in your arms, hands, legs, or feet?	______	______
Have you ever had a stinger, bummer, or pinched nerve?	______	______
8. Have you ever become ill from exercising in the heat?	______	______
9. Do you cough, wheeze, or have trouble breathing during or after activities?	______	______
Do you have asthma?	______	______
Do you have seasonal allergies that require medical treatment?	______	______
10. Do you use any special or corrective equipment or devices that aren't usually used for our sport or position (e.g., knee brace, special neck roll, foot orthotics, retainer on your teeth, or hearing aid)?	______	______
11. Have you had any problems with your eyes or vision?	______	______
Do you wear glasses, contacts, or protective eyewear?	______	______
12. Have you ever had a sprain, strain, or swelling after an injury?	______	______
Have you broken or fractured any bones or dislocated any joints?	______	______
Have you ever had any other problems with pain or swelling in muscles, tendons, bones, or joints?	______	______

If yes, check and explain below.

____ Head	____ Elbow	____ Hip
____ Neck	____ Forearm	____ Thigh
____ Back	____ Wrist	____ Knee
____ Chest	____ Hand	____ Shin/calf
____ Shoulder	____ Finger	____ Ankle
____ Upper arm	____ Foot	____

	Yes	No
13. Do you want to weigh more or less than you do now?	______	______
Do you lose weight regularly to meet weight requirements for your sport?	______	______
14. Do you feel stressed out?	______	______

15. Record the dates of your most recent immunizations for:

Tetanus	__________	Measles	____________
Hepatitis B	__________	Chickenpox	____________

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	Date