

# WARREN COUNTY SCHOOLS PRE-PARTICIPATION PHYSICAL FORM

## PERSONAL INFORMATION

Name: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

Home Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Sports: \_\_\_\_\_

Father: \_\_\_\_\_ Home# \_\_\_\_\_ Cell# \_\_\_\_\_ Work# \_\_\_\_\_

Mother: \_\_\_\_\_

Another Person to Contact: \_\_\_\_\_

Insurance Co: \_\_\_\_\_ Group/Policy # \_\_\_\_\_

## HEALTH HISTORY: Please explain any "Yes" answers.

Yes No

		Chronic or recurrent illness (asthma, diabetes, infectious mononucleosis, etc...)?
		Have you ever been hospitalized?
		Have you ever passed out during exercise?
		Have you ever been dizzy during or after exercise?
		Have you ever had chest pain during exercise?
		Do you tire more quickly than your friends during exercise?
		Have you ever had high blood pressure?
		Have you ever been told you have a heart murmur?
		Has anyone in your family died from a heart problem, or a sudden death, before the age of 50?
		Have you ever had a head injury (concussion)?
		Have you ever been knocked unconscious?
		Have you ever had a seizure?
		Do you have trouble breathing or do you cough during or after exercise?
		Have you had any problems with your eyes or vision?
		Do you wear glasses or contacts?
		Do you have any skin problems (itching, rashes, etc...)?
		Have you ever had a stinger/burner or pinched nerve?
		Have you had a medical problem since your last sports physical?

- List any surgeries you have had. \_\_\_\_\_
- List any medications you are presently taking. \_\_\_\_\_
- List any allergies (medicine, bee stings, food, etc...) you have. \_\_\_\_\_
- When was your last tetanus shot? \_\_\_\_\_
- Please circle any body part/area that you have injured or had repeated swelling. Explain any injuries just below.

Head    Shoulder    Elbow    Wrist    Chest    Hip    Knee    Ankle    Foot  
 Neck    Arm    Forearm    Hand    Back    Thigh    Lower Leg    Other

## MEDICAL CONSENT TO TREAT

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

I/We hereby grant permission to (school) \_\_\_\_\_, its physicians, and/or Athletic Trainers, to render aid, treatment, medical or surgical care deemed reasonably necessary to the health and well being of the above individual.

I/We further authorize the Athletic Trainers at the above-named institution, who are under the direction and guidance of a physician, to render any first aid, preventive rehabilitation, or emergency treatment deemed reasonably necessary to protect the health and well being of the above individual.

I/We additionally grant, when necessary for protecting the health and well being of the above individual, permission for hospitalization, treatment, or surgery at a competent and/or accredited facility.

I/We further release (school) \_\_\_\_\_, its Athletic Trainers, agents, servants, and employees, from any liability for damages and injury to the above individual and hereby accept full responsibility for any and all damages or injuries sustained as a result of participation in his/her chosen sport or extracurricular activity.

**SIGNATURES:** Student: \_\_\_\_\_ Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**PHYSICIANS EVALUATION**

Students Name: \_\_\_\_\_ School: \_\_\_\_\_

**GENERAL MEDICAL:**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BP: \_\_\_\_\_ / \_\_\_\_\_ Pulse: \_\_\_\_\_

Vision: R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ Corrected? Y N Pupils: Equal Unequal

	Normal	Abnormal Findings
Ears, Nose, Throat		
Heart		
Chest/Lungs		
Skin/Lymphatics		
Abdominals		
Genitalia/Hernia		

**MUSCULOSKELETAL**

	Normal	Abnormal Findings
Neck/Back		
Upper Extremities		
Lower Extremities		
Flexibility		

**Optional Lab** Urine Sugar: \_\_\_\_\_ Urine Protein: \_\_\_\_\_ Urine Hematest: \_\_\_\_\_

**RECOMMENDATION**

- Cleared for participation
- Cleared after completing evaluation/rehabilitation for \_\_\_\_\_.
- Not cleared due to \_\_\_\_\_.

Physicians Signature: \_\_\_\_\_

Date: \_\_\_\_\_