

ALABAMA HIGH SCHOOL ATHLETIC ASSOCIATION

Preparticipation Physical Evaluation Form

History

Name _____ Sex _____ Age _____ Date _____
 Address _____ Date of birth _____
 School _____ Grade _____ Phone _____
 Sport _____

Explain "Yes" answers below:	Yes	No
1. Has a doctor ever restricted/denied your participation in sports?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized or spent a night in a hospital? Have ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have any ongoing medical conditions (like Diabetes or Asthma)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you presently taking any medications or pills (prescription or over-the-counter)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any allergies (medicine, pollens, foods, bees or other stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever passed out during or after exercise? Have you ever been dizzy during or after exercise? Have you ever had chest pain or discomfort in your chest during or after exercise? Do you tire more quickly than your friends during exercise? Have you ever had high blood pressure? Have you ever been told that you have a heart murmur, high cholesterol, or heart infection? Have you ever had racing of your heart or skipped heartbeats? Has anyone in your family died of heart problems or a sudden death before age 50? Does anyone in your family have a heart condition? Has a doctor ever ordered a test on your heart (EKG, echocardiogram)?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have any skin problems (itching, rashes, staph, MRSA, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever had a head injury or concussion? Have you ever been knocked out or unconscious? Have you ever had a seizure? Have you ever had a stinger, burner, pinched nerve, or loss of feeling or weakness in your arms or legs?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever had heat or muscle cramps? Have you ever been dizzy or passed out in the heat?	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have trouble breathing or do you cough during or after activity? Do you take any medications for asthma (for instance, inhalers)?	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you had any problems with your eyes or vision? Do you wear glasses or contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you had any other medical problems (infectious mononucleosis, diabetes, infectious diseases, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you had a medical problem or injury since your last evaluation?	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you ever been told you have sickle cell trait? Has anyone in your family had sickle cell disease or sickle cell trait?	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints? <input type="checkbox"/> Head <input type="checkbox"/> Back <input type="checkbox"/> Shoulder <input type="checkbox"/> Forearm <input type="checkbox"/> Hand <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Neck <input type="checkbox"/> Chest <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Finger <input type="checkbox"/> Thigh <input type="checkbox"/> Shin <input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>
17. When was your first menstrual period? _____ When was your last menstrual period? _____ What was the longest time between your periods last year? _____		
Explain "Yes" answers: _____ _____ _____		

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

Signature of athlete _____ Date _____

Signature of parent/guardian _____

DUPLICATE AS NEEDED

Preparticipation Physical Evaluation

Rule 1, Sec. 14 — In order for a student to be eligible for interscholastic athletics, there must be on file in the Superintendent's or Principal's office a current physician's statement certifying that the student has passed a physical exam, and that in the opinion of the examining physician (M.D. or D.O.) the student is fully able to participate in interscholastic athletics (Grade s 7-12). The AHSAA Physicians Certificate (Form 5) must be used. **A physical exam will satisfy the requirement for one calendar year from the date of the exam.**

Physical Examination

LIMITED	Height _____ Weight _____ BP ____ / ____ Pulse _____		
	Vision R 20 / ____ L 20 / ____ Corrected: Y N		
		Normal	Abnormal Findings
	Cardiovascular		
	Pulses		
	Heart		
	Lungs		
	Skin		
	E.N.T.		
	Abdominal		
	Genitalia (males)		
	Musculoskeletal		
	Neck		
	Shoulder		
	Elbow		
	Wrist		
	Hand		
	Back		
	Knee		
	Ankle		
Foot			
Other			

Clearance:

A. Cleared

B. Cleared after completing evaluation/rehabilitation for: _____

C. Not cleared for: Collision Contact Noncontact _____ Strenuous _____ Moderately strenuous _____ Nonstrenuous

Due to: _____

Recommendation: _____

Name of physician _____ Date _____

Address _____ Phone _____

Signature of physician _____, M.D. or D.O.



Pediatric Cardiac Risk Assessment Form

Complete this form for each person under the age of 50, including children, periodically during well child visits including neonatal, preschool, before and during middle school, before and during high school, before college and every few years through adulthood. If you answer "Yes" or "Unsure" to any questions, read the back of this form.

Name: _____

Age: _____

Date: _____

Individual History Questions:	Yes	No	Unsure
Has this person fainted or passed out DURING exercise, emotion or startle?			
Has this person fainted or passed out AFTER exercise?			
Has this person had extreme fatigue associated with exercise (different from others of similar age)?			
Has this person ever had unusual or extreme shortness of breath during exercise?			
Has this person ever had discomfort, pain or pressure in his chest during exercise, or complained of his heart "racing or skipping beats"?			
Has a doctor ever told this person they have: <input type="checkbox"/> high blood pressure <input type="checkbox"/> high cholesterol <input type="checkbox"/> a heart murmur or <input type="checkbox"/> a heart infection? (Check which one, if any.)			
Has a doctor ever ordered a test for this person's heart? If yes, what test and when?			
Has this person ever been diagnosed with an unexplained seizure disorder or exercise-induced asthma? If yes, which one and when?			
Has this person ever been diagnosed with any form of heart/cardiovascular disease? If yes, what was the diagnosis?			
Is this person adopted, or was an egg or sperm donor used for conception?			
Family History Questions (think of grandparents, parents, aunts, uncles, cousins and siblings):			
Are there any family members who had a sudden, unexpected, unexplained death before age 50? (including SIDS, car accident, drowning, passing away in their sleep, or other)			
Are there any family members who died suddenly of "heart problems" before age 50?			
Are there any family members who have had unexplained fainting or seizures?			
Are there any family members who are disabled due to "heart problems" under the age of 50?			
Are there <u>any</u> relatives with certain conditions such as:			
Check the appropriate box: <input type="checkbox"/> Hypertrophic cardiomyopathy (HCM) <input type="checkbox"/> Dilated cardiomyopathy (DCM)			
Check the appropriate box: <input type="checkbox"/> Arrhythmogenic right ventricular cardiomyopathy (ARVC), <input type="checkbox"/> Long QT syndrome (LQTS), <input type="checkbox"/> Short QT syndrome, <input type="checkbox"/> Brugada syndrome, <input type="checkbox"/> Catecholaminergic ventricular tachycardia			
Coronary artery atherosclerotic disease (Heart attack, age 50 years or younger)			
Check the appropriate box: <input type="checkbox"/> Aortic rupture or Marfan syndrome <input type="checkbox"/> Ehlers-Danlos syndrome <input type="checkbox"/> Primary pulmonary hypertension <input type="checkbox"/> Congenital deafness (deaf at birth)			
<input type="checkbox"/> Pacemaker or <input type="checkbox"/> implanted cardiac defibrillator (if yes, whom and at what age was it implanted?)			
Other form of heart/cardiovascular disease or mitochondrial disease			
Has anyone in the family had genetic testing for a heart disease? If yes, for what disease? _____ Was a gene mutation found? Circle one: YES/NO			
Explain more about any "yes" answers here:			