PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Name:	Date of birth:			
Date of examination:	Sport(s):			
Sex assigned at birth (F, M, or intersex):				
List past and current medical conditions.				
Have you ever had surgery? If yes, list all past sur	gical procedures.			
Medicines and supplements: List all current preso	riptions, over-the-counter medicines, and supplements (herbal and nutritional)			

Patient Health Questionnaire Version 4 (PHQ-4)	a u .f	d - (-11	12 /C:l	1
Over the last 2 weeks, how often have you been be				
	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(Exp	IERAL QUESTIONS lain "Yes" answers at the end of this form. e questions if you don't know the answer.)	Yes	No
1.	Do you have any concerns that you would like to discuss with your provider?		
2.	Has a provider ever denied or restricted your participation in sports for any reason?		
3.	Do you have any ongoing medical issues or recent illness?		
HEA	RT HEALTH QUESTIONS ABOUT YOU	Yes	No
4.	Have you ever passed out or nearly passed out during or after exercise?		
5.	Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6.	Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7.	Has a doctor ever told you that you have any heart problems?		
8.	Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

STORY OF BRIDE	rt Health Questions about you ntinued)	Yes	No
9.	Do you get light-headed or feel shorter of breath than your friends during exercise?		
10.	Have you ever had a seizure?		
HEA	rt health questions about your family	Yes	No
11.	Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
12.	Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13.	Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

	NE AND JOINT QUESTIONS	Yes	No	MEDICAL QUESTIONS (CONTINUED)	Yes	No
4.	Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that			25. Do you worry about your weight?		
	caused you to miss a practice or game?		Ш	26. Are you trying to or has anyone recommended that you gain or lose weight?		
5.	Do you have a bone, muscle, ligament, or joint injury that bothers you?			27. Are you on a special diet or do you avoid certain types of foods or food groups?		
۸EC	DICAL QUESTIONS	Yes	No	28. Have you ever had an eating disorder?		
5.	Do you cough, wheeze, or have difficulty breathing during or after exercise?			FEMALES ONLY	Yes	No
7.	Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?			Have you ever had a menstrual period? 30. How old were you when you had your first menstrual period?		
8.	Do you have groin or testicle pain or a painful bulge or hernia in the groin area?			31. When was your most recent menstrual period?		
9.	Do you have any recurring skin rashes or			32. How many periods have you had in the past 12 months?		
	rashes that come and go, including herpes or methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)?			Explain "Yes" answers here.		
Э.	Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?					
1.	Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?					
	weakness in your arms or legs, or been unable to move your arms or legs after being hit or					
2.	weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling? Have you ever become ill while exercising in the					

Signature of athlete: Signature of parent or guardian:

and correct.

tional purposes with acknowledgment.

No

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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 cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
 - During the past 30 days, did you use chewing tobacco, snuff, or dip?
 - Do you drink alcohol or use any other drugs?

Signature of health care professional: _

- Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
- Have you ever taken any supplements 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 (Q4-Q13 of History Form).

EXAMINATION					
Height: Weight:					
BP: / (/) Pulse:	Vision: R 20/	L 20/	Correcte	ed: □ Y [□ N
MEDICAL				NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched myopia, mitral valve prolapse [MVP], and ao		nodactyly, hyperl	axity,		
Eyes, ears, nose, and throat Pupils equal Hearing					
Lymph nodes					
Heart ^a • Murmurs (auscultation standing, auscultation)	supine, and ± Valsalva maneuver)			
Lungs					
Abdomen					<u> </u>
Skin • Herpes simplex virus (HSV), lesions suggestive tinea corporis	of methicillin-resistant Staphyloc	occus aureus (MR	SA), or		
Neurological					
MUSCULOSKELETAL				NORMAL	ABNORMAL FINDINGS
Neck					
Back					
Shoulder and arm					
Elbow and forearm					
Wrist, hand, and fingers					
Hip and thigh					
Knee					
Leg and ankle					
Foot and toes					
Functional Double-leg squat test, single-leg squat test, an					
^a Consider electrocardiography (ECG), echocardio nation of those.	graphy, referral to a cardiologist	for abnormal car	diac histor	y or examin Dat	

, MD, DO, NP, or PA

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PREPARTICIPATION PHYSICAL EVALUATION **MEDICAL ELIGIBILITY FORM**

SIGNATURE OF PARENT/GUARDIAN

WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION - ATHLETIC PERMIT CARD

(Print or Type)

ALL STUDENTS PARTICIPATING IN INTERSCHOLASTIC ATE Physical examination taken April 1 and thereafter is valid for the foll and the following school year.	HLETICS MUST HAVE THIS CA Nowing two school years; physica	RD ON FILE AT THEIR SCHOOL <u>PRIOF</u> al examination taken before April 1 is valid	RETO PRACTICE OR PARTICIPATION d only for the remainder of that school year
NAME (Last)	(First)	(Middle Initial)	Date of Birth
Age Sex assigned at birth (F, M or intersex) Grade			
Present Address			
☐ Medically eligible for all sports without restriction			
☐ Medically eligible for all sports without restriction with recommen	ndations for further evaluation or	treatment of	
☐ Medically eligible for certain sports			
☐ Not medically eligible pending further evaluation			
☐ Not medically eligible for any sports			
Recommendations:			
-			
I have examined the above-named student and completed the prep ticipate in the sport(s) as outlined on this form. A copy of the phys conditions arise after the athlete has been cleared for participation, pletely explained to the athlete (and parents/guardians). Name of health care professional (Print/Type)	sical exam findings are on record , the physician may rescind the m	in my office and can be made available t edical eligiblity until the problem is resolv	o the scridol at the request of the patents. It
SIGNATURE OF HEALTH CARE PROFESSIONAL (MD OR DO)/PA/A	\PNP*:		
Clinic Name			
Address/Clinic			
Telephone			
* PHYSICIANS may authorize Nurse Practitioners to			ion the physician is anniated.
Parents' Place of Employment			
Family Physician	Family		
Name of Private Insurance Carrier		Telephone	
Subscriber Member Name (Primary Insured)			
Emergency Information			
Allergies			
Medications			
Other Information			
Immunizations	enza; poliomyelitis; pneumococcal;	meningococcal; varicella)	
1. I hereby give my permission for the above named student to p. 2. Pursuant to the requirements of the Health Insurance Portability a providers of the student named above, including emergency mer change essential medical information regarding the injury and tre Team Physician, Team Coach, Administrative Assistant to the Ath	practice and compete and represer and Accountability Act of 1996 and the dical personnel and other similarly to person of this student to appropriate	nt the school in WIAA approved interschola ne regulations promulgated thereunder (collections professionals that may be attending at eschool district personnel such as but not limited health care providers, for purposes of treat	tively known as "HPAA", I authorize health cain interscholastic event or practice, to disclose/ex ited to: Principal, Athletic Director, Athletic Traine ment, emergency care and injury record-keeping
CICNIATURE OF DADENT/CHARDIAN		DA [*]	TE

PREPARTICIPATION PHYSICAL EVALUATION MEDICAL ELIGIBILITY FORM

SIGNATURE OF PARENT/GUARDIAN

WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION - ATHLETIC PERMIT CARD

(Print or Type)

ALL STUDENTS PARTICIPATING IN INTERSCHOLASTIC ATHLETICS MUST HAVE THIS CARD ON FILE AT THEIR SCHOOL PRIOR TO PRACTICE OR PARTICIPATION Physical examination taken April 1 and thereafter is valid for the following two school years; physical examination taken before April 1 is valid only for the remainder of that school year and the following school year. (First) ______ (Middle Initial) _____ Date of Birth ____ NAME (Last) Age _____ Sex assigned at birth (F, M or intersex) ____ Grade ____ School _____ Telephone ☐ Medically eligible for all sports without restriction ☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of ☐ Medically eligible for certain sports ☐ Not medically eligible pending further evaluation ☐ Not medically eligible for any sports Recommendations: I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical exam findings are 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 medical eligiblity until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardlans). Name of health care professional (Print/Type) ___ SIGNATURE OF HEALTH CARE PROFESSIONAL (MD OR DO)/PA/APNP*: ______ City ______ State _____ Zip Code _____ Address/Clinic Date of Examination ____ Telephone * PHYSICIANS may authorize Nurse Practitioners to stamp this card with the physician's signature or the name of the clinic with which the physician is affiliated. Parents' Place of Employment ____ Family Physician ____ _____ Family Dentist _____ _____Telephone ____ Name of Private Insurance Carrier ____ Subscriber Member Name (Primary Insured) **Emergency Information** Allergies Medications_ Other Information _ (e.g., tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; poliomyelitis; pneumococcal; meningococcal; varicella) 1. I hereby give my permission for the above named student to practice and compete and represent the school in WIAA approved interscholastic sports except those restricted on this card. 2. Pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder (collectively known as "HIPAA"), I authorize health care

providers of the student named above, including emergency medical personnel and other similarly trained professionals that may be attending an interscholastic event or practice, to disclose/exchange essential medical information regarding the injury and treatment of this student to appropriate school district personnel such as but not limited to: Principal, Athletic Director, Athletic Trainer, Team Physician, Team Coach, Administrative Assistant to the Athletic Director and/or other professional health care providers, for purposes of treatment, emergency care and injury record-keeping.

DATE ___