CIF PRE-PARTICIPATION PHYSICAL EVALUATION

CLEARANCE FORM (TO BE SIGNED BY PHYSICIAN AND UPLOADED TO 'REGISTER MY ATHLETE')
ATHLETIC PHYSICALS ARE GOOD FOR ONE CALENDAR YEAR FROM THE DATE OF PHYSICIAN'S SIGNATURE

Name_____ □ Male □ Female Age_____ Date of Birth _____

Sports: Fall _____ Winter _____ Spring _____

CLEARANCE

□ **Cleared for all sports without restriction**

□ **Cleared for all sports without restriction with recommendation for further evaluation or treatment for:**
_____

□ **Not cleared □ Pending further evaluation**
□ For any sports
□ For certain sports _____Reason_____

Recommendations:
_____
_____
_____
_____
_____

I have examined the above-named student and completed the pre-participation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is 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 clearance until the problem is resolved and the potential consequences are completely explained to the athlete and his/her parents/guardian.

Name of physician (print/type) _____MD or DO Date of Exam_____

Signature_____ Date of Signature_____

Address _____Phone _____

EMERGENCY INFORMATION

ALLERGIES:
_____
_____
_____
_____

OTHER INFORMATION:
_____
_____
_____
_____
_____
_____

CIF PRE-PARTICIPATION PHYSICAL EVALUATION: HISTORY FORM (TO BE RETAINED BY PHYSICIAN)

(This form is to be filled out by the parent/patient prior to seeing the physician. The physician should keep this it in the medical chart.)

Name_____ Date of Exam _____ School_____
Gender_____ Date of Birth_____ Grade_____Sport(s)_____

Medicines and Allergies: Please list all the prescriptions and over-the-counter medicines and supplements (herbal and medicinal) that you are currently taking:
–
_____ _____

Do you have any allergies? □ Yes □ No If yes, please identify the specific allergy(ies):
□ Pollens _____ □ Food _____ □ Medicines _____ □ Insects_____ □ Other
_____

Explain 'yes' answers on the back of this page. Circle questions you don't know the answer to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? Identify: □ Asthma □ Anemia □ Diabetes □ Infection □Other:		
3. Have you ever spent the night in a hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: □ High blood pressure □ A heart murmur □ High cholesterol □ A heart infection □ Kawasaki disease □ Other _____		
9. Has a doctor ever ordered a test for your heart? (i.e. EKG/ECG, echocardiogram)		
10. Do you get light-headed or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident or sudden infant death syndrome)?		
14. Does anyone in your family have hypertropic cardiomyopathy, Marfan syndrome, anthythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures or near drowning?		
BONE AND JOINT QUESTIONS	Yes	No
17. Have you ever had an injury to a bone, muscle, ligament or tendon that caused you to miss a practice or game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoxial instability, Down syndrome or dwarfism?		
22. Do you regularly use a brace, orthotics or other assistive device?		
23. Do you have a bone/muscle/joint injury bothering you?		
24. Do any of your joints become painful, swollen, feel warm or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		
MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze or have difficulty breathing during or af ter exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen or any other organ?		
30. Do you have groin pain or painful bulge/hernia in the groin?		
31. Have you had infectious mononucleosis (mono) in the last month?		
32. Do you have any rashes, pressure sores or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps while exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear such as goggles or face shield?		
47. Do you worry about your weight?		
48. Are you trying or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Are you currently using any prescription or over-the-counter medications?		
52. Do you drink alcohol?		
53. Do you smoke or vape with plain or nicotine/marijuana laced juices?		
54. Have you every used any illegal drugs including marijuana, opiods or other?		
55. Have you ever taken anabolic steroids or used any other supplement to gain or lose weight or improve performance?		
56. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY	Yes	No
57. Have you ever had a menstrual period?		
58. How old were you when you had your first menstrual period?		
59. How many periods have you had in the last 12 months?		

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

Signature of student_____ Signature of parent_____ Date_____ ©

CIF PRE-PARTICIPATION PHYSICAL EVALUATION:
PHYSICAL EXAMINATION FORM (TO BE RETAINED BY PHYSICIAN)

Name _____ Date of exam_____

PHYSICIAN REMINDERS (This form should be kept in the medical records)

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 vaping, cigarettes, chewing tobacco, snuff or dip?**
   - **During the past 30 days, have you vaped or used cigarettes, chewing tobacco, snuff or dip?**
   - **Do you drink alcohol or use any other drugs?**
   - **Have you ever taken anabolic steroids or used any other performance supplement?**
   - **Have you ever taken any supplements to help you gain orlose weight or improve your performance?**
   - **Do you always wear a seat belt, use a helmet and use condoms.**

2. **Consider reviewing questions on cardiovascular symptoms (questions 5-14)**

EXAMINATION		
Height Weight □ Male □ Female Date of birth:		
BP / (/) Pulse Vision: R 20/ L 20/ Corrected? □ Yes □ No		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance: Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/Ears/Nose/Throat: Pupils equal, Hearing		
Lymph nodes		
Heart[1]: Murmurs (auscultation standing, supine, ± Valsalva) Location of point of maximal impulse (PMI)		
Pulses: Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[2]		
Skin: HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[3]		
MUSCULAR/SKELETAL		
Neck		
Back		
Shoulder/Arms		
Elbow/Forearm		
Wrist/Hands/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		
Functional: Duck-walk, single leg hop		

[1]Consider ECG, echocardiogram and referral to cardiology for abnormal cardiac history or exam
[2]Consider GU exam if in a private setting. Having a third party present is recommended.
[3]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion

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□ **Cleared for all sports without restriction with recommendation for further for further evaluation or treatment for**_____
_____
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□ **For certain sports: Reason: _____**
Recommendations _ _____

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