

Preparticipation Physical Evaluation

HISTORY FORM

Date of Exam _____

Name _____ Sex _____ Age _____ Date of birth _____
 Grade _____ School _____ Sport(s) _____
 Address _____ Phone _____
 Personal Physician _____

In case of emergency, contact:

Name _____ Relationship _____ Phone (H) _____ Phone (W) _____

**Explain "Yes" answers below.
Circle questions you don't know the answers to.**

		Yes	No			Yes	No
1.	Has a doctor ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	24.	Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Do you have an ongoing medical condition (like diabetes or asthma)?	<input type="checkbox"/>	<input type="checkbox"/>	25.	Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	<input type="checkbox"/>	<input type="checkbox"/>	26.	Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Do you have allergies to medicines, pollens, foods, or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>	27.	Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Have you ever passed out or nearly passed out DURING exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28.	Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Have you ever passed out or nearly passed out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	29.	Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Have you ever had discomfort, pain, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	30.	Have you had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
8.	Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	31.	Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
9.	Has a doctor ever told you that you have (check all that apply):			32.	Have you been hit in the head and been confused or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> High blood pressure			33.	Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> A heart murmur			34.	Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> High cholesterol			35.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> A heart infection			36.	Have you ever been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
10.	Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram)	<input type="checkbox"/>	<input type="checkbox"/>	37.	When exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>
11.	Has anyone in your family died for no apparent reason?	<input type="checkbox"/>	<input type="checkbox"/>	38.	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
12.	Does anyone in your family have a heart problem?	<input type="checkbox"/>	<input type="checkbox"/>	39.	Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
13.	Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	40.	Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
14.	Does anyone in your family have Marfan syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	41.	Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
15.	Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	42.	Are you happy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>
16.	Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	43.	Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
17.	Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below:	<input type="checkbox"/>	<input type="checkbox"/>	44.	Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>
18.	Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	<input type="checkbox"/>	<input type="checkbox"/>	45.	Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>
19.	Have you had a bone or joint injury that required x-rays MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:	<input type="checkbox"/>	<input type="checkbox"/>	46.	Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/ Fingers	Chest
Upper Back	Lower Back	Hip	Thigh	Knee	Calf/ Shin	Ankle	Foot/ Toes
20.	Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>	47.	Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
21.	Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	<input type="checkbox"/>	<input type="checkbox"/>	48.	How old were you when you had your first menstrual period? _____		
22.	Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>	49.	How many periods have you had in the last 12 months? _____		
23.	Has a doctor ever told you that you have asthma or allergies?	<input type="checkbox"/>	<input type="checkbox"/>	Explain "Yes" answers here: _____			

FEMALES ONLY

47. Have you ever had a menstrual period? Yes No
 48. How old were you when you had your first menstrual period? _____
 49. How many periods have you had in the last 12 months? _____

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/Guardian _____ Date _____

Preparticipation Physical Evaluation

PHYSICAL EXAMINATION FORM

Name _____ Date of Birth _____

Height _____ Weight _____ % Body Fat (optional) _____ Pulse _____ BP ____ / ____ (____ / ____, ____ / ____)

Vision R 20/____ L 20/____ Corrected: Y N Pupils: Equal _____ Unequal _____

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)+			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

*Multiple-examiner set-up only.

+Having a third party present is recommended for the genitourinary examination.

Notes: _____

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

Preparticipation Physical Evaluation

CLEARANCE FORM

Name _____ Sex _____ Age _____ Date of birth _____

- Cleared without restriction
- Cleared, with recommendations for further evaluation or treatment for: _____

Not Cleared for All sports Certain sports: _____ Reason: _____

Recommendations: _____

EMERGENCY INFORMATION

Allergies _____

Other Information _____

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

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BROOKSTONE SCHOOL

MEDICAL INSURANCE AUTHORIZATION AND WAIVER ATHLETIC PARTICIPATION

My child, _____, has permission to participate in organized athletics provided or sponsored by Brookstone School. I fully realize and acknowledge the possibility of injury involved in participating in high school and/or middle school athletics. I recognize the risk of injury can range from minor to catastrophic, resulting in the possibility of permanent disability, paralysis, or even death.

1. I give my express permission for my child to participate in athletics at Brookstone School including travel associated with participation;
2. I assume any and all risks associated with any special medical needs* or conditions of my child during participation in athletics, as well as associated travel;
3. I authorize any coach or adult supervising any athletic activity in which my child participates to obtain on behalf of my child, and at my expense, any necessary emergency medical services which may be required as a result of an injury to my child in connection with such participation (including travel incident thereto);
4. I certify that I have insurance reasonably sufficient to cover my child against injury and loss of life caused to my child or caused by my child in connection with such participation; and
5. I agree that all expenses relating to or arising out of any such injuries or loss of life will be my responsibility, and my child and I agree to release, hold harmless and indemnify Brookstone School and its officers, employees, trustees against any and all claims, liabilities, damages and expenses, including reasonable attorney's fees, with respect to injuries, regardless of severity, or loss of life relating to my child's participation in athletics.

- Note: Special medical needs or conditions of my child include:

Full Name of Athlete _____ Grade _____

Sport (s) _____ School Year _____

SSN: _____ DOB: _____

Parent or Legal Guardian Name _____

Home Phone # _____ Cell # _____

Policy Holders Name _____

Insurance Company _____

Policy # _____ Group # _____

Emergency Contact Name and Number _____

Signature of Parent/Legal Guardian _____

Date: _____