Anaheim Union H.S. District Pre-Participation Physical Evaluation

Name____Sex________Age________Date of birth___________________

Grade_________School___________________________________Sport(s)____

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

Question	Answer
1. Has a doctor ever denied or restricted your participation in sports for any reason?	Yes No
2. Do you have an ongoing medical condition (like diabetes or asthma)?	Yes No
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills?	Yes No
4. Do you have any allergies to medicines, pollens, foods, or stinging insects?	Yes No
5. Have you ever passed out or nearly passed out DURING exercise?	Yes No
6. Have you ever passed out or nearly passed out AFTER exercise?	Yes No
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	Yes No
8. Does your heart race or skip beats during exercise?	Yes No
9. Has a doctor ever told you that you have (check all that apply): High blood pressure; Heart murmur; High cholesterol; Heart infection	Yes No
10. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)	Yes No
11. Has anyone in your family died for no apparent reason?	Yes No
12. Does anyone in your family have a heart problem?	Yes No
13. Has any family member or relative died of heart problems or of sudden death before age 50?	Yes No
14. Does anyone in your family have Marfan syndrome?	Yes No
15. Have you ever spent the night in a hospital?	Yes No
16. Have you ever had surgery?	Yes No
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:	Yes No
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	Yes No
19. Have you had a bone or joint injury that required xrays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:	Yes No
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?	Yes No
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	Yes No
22. Do you regularly use a brace or assistive device?	Yes No
23. Has a doctor ever told you that you have asthma or allergies?	Yes No
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	Yes No
25. Is there anyone in your family who as asthma?	Yes No
26. Have you ever used an inhaler or taken asthma medicine?	Yes No
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	Yes No
28. Have you had infectious mononucleosis (mono) within the last month?	Yes No
29. Do you have any rashes, pressure sores, or other skin problems?	Yes No
30. Have you had a herpes skin infection?	Yes No
31. Have you ever had a head injury or concussion?	Yes No
32. Have you been hit in the head and been confused or lost your memory?	Yes No
33. Have you ever had a seizure?	Yes No
34. Do you have headaches with exercise?	Yes No
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	Yes No
36. Have you ever been unable to move your arms or legs after being hit or falling?	Yes No
37. When exercising in the heat, do you have severe muscle cramps or become ill?	Yes No
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	Yes No
39. Have you had any problems with your eyes or vision?	Yes No
40. Do you wear glasses or contact lenses?	Yes No
41. Do you wear protective eyewear, such as goggles or a face shield?	Yes No
42. Are you happy with your weight?	Yes No
43. Are you trying to gain or lose weight?	Yes No
44. Has anyone recommended you change your weight or eating habits?	Yes No
45. Do you limit or carefully control what you eat?	Yes No
46. Do you have any concerns that you would like to discuss with a doctor?	Yes No
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**_________

Physician's Physical Evaluation – **Exam must be completed ON or AFTER May 20, 2023** to be valid for 2023-24 school year

Height______Weight________% Body fat (optional)_________Pulse________BP____/_____ (_____/_____ ,_____/_____)

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

○ Cleared ○ Cleared after completing evaluation/rehabilitation for:______________________________

○ Not cleared for:______________________________ Reason:______________________________

Name of physician (print/type) ______________________________ **Date of Physical** ____________________

Doctor's Address/Phone – Any doctor's stamp MUST INCLUDE DOCTOR'S NAME ______________________________

Signature of physician______________________________ ○ MD or ○ DO License #_______________ **Physical MUST be signed by MD or DO – not PAC, RNP, DC, etc.**