Los Angeles Unified School District
Pre-Participation Physical Evaluation

Date of Exam: _____ ATTACHMENT A

Student's Name: _____ Sex: _____ Age: _____ Date of Birth: _____ Grade: _____

School: _____ Sport(s): _____

Address: _____ Phone: _____

Personal Physician/Provider: _____

In case of emergency, contact: Name: _____ Relationship: _____

Telephone: (Home) _____ (Work) _____ (Cell) _____ (Cell) _____

Medicines and Allergies: Please list all the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking.

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging insects

This section is to be carefully completed by the student and his/ her parent(s) or legal guardian(s) before participation in interscholastic athletics. Explain Yes answers below. Circle questions you don't know the answers 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? If so, please identify below: ☐Asthma ☐Anemia ☐Diabetes ☐Infections 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: ☐ Kawasaki disease ☐ A Heart Infection ☐ High Blood Pressure ☐ A Heart Murmur ☐ High Cholesterol Other:_____		
9. Has a doctor ever ordered a test for your heart (for example, ECG/EKG, echocardiogram)?		
10. Do you get lightheaded 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?		
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 hypertrophic cardiomyopathy, Marfan syndrome, arrythmogenic 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, like a sprain, muscle, or ligament tear, or tendinitis that caused you to miss a practice or game?		
18. Have you 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 been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics or other assistive device?		
23. Do you have a bone, muscle or joint injury that bothers 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 after 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 a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within 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 when 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 a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of food?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here:

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

Signature of athlete_____ Signature of parent/guardian _____ Date_____

Physical Examination Form

The section below is to be completed by physician or staff after history and consent forms are completed.

ATTACHMENT A

Student's Name: _____ DOB: _____

Height: _____ Weight: _____ %BMI (optional): _____ Pulse: _____ BP: _____/ _____, (_____/ _____, _____/ _____)

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

EMERGENCY INFORMATION

Allergies: _____

Other Information: _____

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)		
Lungs		
Abdomen		
Genitourinary (males only) [2]		
Skin ● HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic [3]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/ Arm		
Elbow/ Forearm		
Wrist/ Hand/ 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 private setting. Having 3rd party present is recommended.

[3] Consider cognitive evaluation or baseline neuropsychiatric setting if a history of significant concussion.

Clearance

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for: _____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports: _____

Reason/Recommendations: _____

I have evaluated the above named student and completed the pre-participation physical evaluation. The athlete does not present apparent contraindications to practice, tryout 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 parent. 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 parents/guardians).

Name of Physician/ Provider: (print/ type/ stamp) _____ (MD, DO, NP or PA) Date: _____

Address: _____ Phone: _____

Signature of Physician/ Provider: _____

Modified from American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine, 2010.