

PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

Name _____

Date of birth _____

PHYSICIAN REMINDERS

- 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 inhaled 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?
 - Have you ever taken anabolic steroids or used any other performance 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?
- Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height _____	Weight _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
BP _____ / _____	Pulse _____	Vision R 20/ _____ L 20/ _____ Corrected <input type="checkbox"/> Y <input type="checkbox"/> N
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* • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)*		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic*		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

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

- 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 examined the above-named student and completed the preparticipation 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 parents/guardians).

Name of physician (print/type) _____ Date _____
 Address _____ Phone _____
 Signature of physician _____, MD or DO

PREPARTICIPATION PHYSICAL EVALUATION CLEARANCE FORM

Name _____ Sex M F Age _____ Date of birth _____

- 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 examined the above-named student and completed the preparticipation 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 parents/guardians).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

EMERGENCY INFORMATION

Allergies _____

Other information _____

**VALDOSTA HIGH SCHOOL
WAIVER AND EMERGENCY CONSENT FORM**

STUDENT INFORMATION

STUDENT NAME: _____ SSN: _____
STREET ADDRESS: _____ PH#: _____
DATE OF BIRTH: _____ AGE: _____ GRADE: _____ SEX: MALE FEMALE
ALLERGIES OR MEDICATION TAKEN: _____

PARENT INFORMATION

FATHER: _____ PLACE OF EMPLOYMENT: _____
ADDRESS: _____ PH#: (H) _____ (W) _____
MOTHER: _____ PLACE OF EMPLOYMENT: _____
ADDRESS: _____ PH#: (H) _____ (W) _____

CLOSEST RELATIVE TO CONTACT IN CASE OF EMERGENCY

NAME: _____ PH# (H) _____ (W) _____

INSURANCE INFORMATION

COMPANY: _____ POLICY HOLDER: _____ POLICY #: _____

WAVIER AND CONSENT FOR PARTICIPATION

I hereby give consent for the above student to represent his or her school in athletic activities offered at Valdosta High School. I understand that the student must have a pre-participation medical examination in order to participate in athletics as stated by the Georgia High School Association rules. I understand that the pre-participation medical examination is only a screening, and is not intended to identify all problems that could result in sudden death during exercise. I give my consent for the student to accompany the school team on local or out of town trips. I give consent for school personnel to call for assistance and/or take my child to a doctor/emergency room if treatment appears to be in order. In the event that I can not be notified of the injury to give parental consent, I authorize the school personnel or certified athletic trainer to sign necessary consent forms so that my child can receive medical treatment. I have read and understand the Valdosta High School athletic department's policy on insurance. I also understand that I am responsible for all medical bills which may arise from injury to my child that are not covered by the athletic department's insurance plan.

I understand the possibility of injury occurs with all athletic activities offered by the Valdosta Board of Education. I understand that the parents and the students assume risk of injury when they are executing this form. However, in the event physicians, certified athletic trainers, or other personnel trained in rendering of first aid are available, as volunteers or other wise and render first aid to any student/athlete during the course of any activities or travel, then I do hereby release and discharge such persons and the Valdosta Board of Education from any liability arising out of any first aid or immediate treatment of injuries.

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

STUDENT SIGNATURE: _____ **DATE:** _____