

## PARTICIPATION PHYSICAL EVALUATION

STUDENT NAME \_\_\_\_\_

STUDENT ID # \_\_\_\_\_

Sport \_\_\_\_\_

Explain "Yes" answers below:

YES

NO

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been hospitalized?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had surgery?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you presently taking any medications or pills?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any allergies (medicine, bees or other stinging insects?)  |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever passed out during or after exercise?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been dizzy during or after exercise?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had chest pains during exercise?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you tire more quickly than your friends during or after exercise?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had high blood pressure?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been told that you have a heart murmur?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had racing of your heart or skipped heartbeats?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Has anyone in your family died of heart problems or a sudden death before age 50?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any skin problems (itching, rashes, acne)?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a head injury?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you even been knocked out or unconscious?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a seizure?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a stinger, burner, or pinched nerve?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had heat or muscle cramps?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been dizzy or passed out in the heat?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have trouble breathing or do you cough during or after activity?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guard, etc.)?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had any problems with your eyes or vision?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you wear glasses or contacts or protective eyewear?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints?  |
|                          |                          | <input type="checkbox"/> Head <input type="checkbox"/> Shoulder <input type="checkbox"/> Thigh <input type="checkbox"/> Neck <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Chest                                 |
|                          |                          | <input type="checkbox"/> Forearm <input type="checkbox"/> Shin/Calf <input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Ankle <input type="checkbox"/> Hip <input type="checkbox"/> Hand <input type="checkbox"/> Foot |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had any other medical problems (infectious mononucleosis, diabetes, etc.)?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had a medical problem or injury since your last evaluation?   |

When was your last tetanus shot? \_\_\_\_\_

When was your last measles immunization? \_\_\_\_\_

When was your first menstrual period? \_\_\_\_\_

When was your last menstrual period? \_\_\_\_\_

What was the longest time between your periods last year? \_\_\_\_\_

Explain "Yes" answers:

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

Signature of Athlete: \_\_\_\_\_

This form must be completed by the student-athlete and the doctor. Please return this form to the SCC Athletic Department or e-mail it to [jlamb9679@stanly.edu](mailto:jlamb9679@stanly.edu)

PARTICIPATION PHYSICAL EVALUATION *Continued...*

Height _____ Weight _____ BP _____ / _____ Pulse _____			
Vision R 20/ _____ Vision L 20/ _____ Corrected: Y N Pupils _____			
	Normal	Abnormal Findings	Initials
Cardiopulmonary			
Pulse			
Heart			
Lungs			
Tanner Stage	1	2	3 4 5
Skin			
Abdominal			
Genitalia			
Musculoskeletal			
Neck			
Shoulder			
Elbow			
Wrist			
Hand			
Back			
Knee			
Ankle			
Foot			
Other			

Clearance:

- A. Cleared
- B. Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_
- C. Not cleared for:
  - Collision
  - Contact
  - Non-contact

Strenuous     Moderately Strenuous     Non-Strenuous

Due to: \_\_\_\_\_

Recommendation: \_\_\_\_\_

Name of Physician \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of Physician \_\_\_\_\_