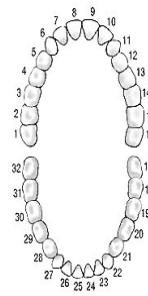


# PRE-PARTICIPATION PHYSICAL EVALUATION AND SCREENING FORM

DATE	NAME	SEX	AGE	DATE OF BIRTH																	
ADDRESS				PHONE NUMBER																	
SCHOOL		GRADE	SPORT																		
PERSONAL PHYSICIAN		PHYSICIAN'S ADDRESS		PHYSICIAN'S PHONE NUMBER																	
<p>EXPLAIN "YES" ANSWERS BELOW</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"> <p>1. Have you ever been hospitalized? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 20px;">Have you ever had surgery? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>2. Are you presently taking any medications or pills? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>3. Do you have any allergies (medicines, bees or other stinging insects)? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>4. 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EXPLANATIONS: _____																					
<p>I hereby state, to the best of my knowledge, my answers to the above questions are correct. Date: _____</p> <p>Signature of Athlete: _____ Social Security #: _____</p> <p>Signature of Parent/Guardian: _____ Social Security #: _____</p>																					
Physical	BLOOD PRESSURE:		HEIGHT:	WEIGHT:	HEART RATE:																
	VISION: (R) 20/_____ (L) 20/_____		Corrected <input type="checkbox"/> Yes <input type="checkbox"/> No																		
Musculoskeletal	NECK	Normal	Abnormal	COMMENTS	BACK	Normal	Abnormal	COMMENTS													
	SHOULDER				KNEE																
	ELBOW				ANKLE																
	WRIST/HAND				HIP																
	COMMENTS:																				
Musculoskeletal	KNEE: OTHER	R _____	L _____	ANTERIOR DRAWER	R _____	L _____	PATELLA ALTA	R _____	L _____												
	ABDUCTION	R _____	L _____	POSTERIOR DRAWER	R _____	L _____	McMURRAYS (if indicated)	R _____	L _____												
	ADDUCTION	R _____	L _____	VMO DYSPLASIA	R _____	L _____	LACHMAM (if indicated)	R _____	L _____												
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	LUNGS				HERNIA (if indicated)																
	SKIN				GENITALIA																
Clearance	<p>1. Cleared: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Cleared after completing evaluation/rehabilitation for: _____</p> <p>3. Not cleared for <input type="checkbox"/> Collision <input type="checkbox"/> Contact <input type="checkbox"/> Noncontact</p>																				
	Recommendations	<p>Physician Name: _____</p> <p>Date: _____</p> <p>Address: _____</p> <p>Physician's Signature: _____</p>																			
					<p>SPECIAL INSTRUCTIONS</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>																