

### ALABAMA HIGH SCHOOL ATHLETIC ASSOCIATION Preparticipation Physical Evaluation

History \_\_\_\_\_ Date \_\_\_\_\_  
 Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_  
 School \_\_\_\_\_ Grade \_\_\_\_\_ Sport **SOCCER**

Explain "Yes" answers below:

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 1. Have you ever been hospitalized? . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had surgery? . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you presently taking any medications or pills? . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have any allergies (medicines, bees or other stinging insects)? . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. 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 pain during or after exercise? . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you tire more quickly than your friends during 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"/> |
| 5. Do you have any skin problems (itching, rashes, acne)? . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever had a head injury? . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever 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"/> |
| 7. 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"/> |
| 8. Do you have trouble breathing or do you cough during or after activity? . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc)? . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you had any problems with your eyes or vision? . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you wear glasses or contacts or protective eye wear? . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever had any other medical problems (infectious mononucleosis, diabetes, etc)? . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever had a medical problem or injury since your last evaluation? . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling<br>or other injuries of any bones or joints? . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Head <input type="checkbox"/> Back <input type="checkbox"/> Shoulder <input type="checkbox"/> Forearm <input type="checkbox"/> Hand <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Ankle |                          |                          |
| <input type="checkbox"/> Neck <input type="checkbox"/> Chest <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Finger <input type="checkbox"/> Thigh <input type="checkbox"/> Shin <input type="checkbox"/> Foot  |                          |                          |
| 14. 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:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

Date \_\_\_\_\_

Signature of athlete \_\_\_\_\_

Signature of parent/guardian \_\_\_\_\_

**DUPLICATE AS NEEDED**

Preparticipation Physical Evaluation

Rule 1, Sec. 13 -- No student shall be eligible to represent his/her school in interscholastic athletics unless there is on file in the Superintendent's or Principal's office a physician's statement for the current year certifying that the student has passed an adequate physical examination, and that in the opinion of the examining physician, he/she is fully able to participate in high school athletics.

Name \_\_\_\_\_

Physical Examination

COMPLETE	LIMITED	Height _____ Weight _____ BP ____/____ Pulse _____	
		Vision R 20 / ____ L 20 / ____ Corrected: Y N	
		Normal	Abnormal Findings
	Cardiopulmonary		
	Pulses		
	Heart		
	Lungs		
	Skin		
	E. N. T.		
	Abdominal		
	Genitalia (males)		
	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 \_\_\_\_ Nonstrenuous

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

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

Name of physician \_\_\_\_\_ Date \_\_\_\_\_

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

Signature of physician \_\_\_\_\_, M.D. or D.O.