

ALABAMA HIGH SCHOOL ATHLETIC ASSOCIATION
Preparticipation Physical Evaluation

History Date _____
 Name _____ Sex _____ Age _____ Date of birth _____
 Address _____ Phone _____
 School _____ Grade _____ Sport _____

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 (medicine, 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, bumer 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 had any other medical problems (infectious mononucleosis, diabetes, etc.)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you 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 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.

Physical Examination

| | | | |
|----------|-------------------|--|-------------------|
| COMPLETE | LIMITED | Height _____ Weight _____ BP _____ / _____ Pulse _____ | |
| | | Vision R 20/ _____ L 20/ _____ Corrected: Y N | |
| | | Normal | Abnormal findings |
| | Cardiovascular | | |
| | 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
 Noncontact ___ Strenuous ___ Moderately strenuous ___ Nonstrenuous

Due to: _____

Recommendation: _____

Name of physician _____ Date _____

Address _____ Phone _____

Signature of physician _____, M.D. or D.O.