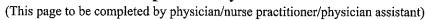
Pre-Participation Physical Evaluation



MARYLAND	
THIC ASSOCIATION	

PHYSICAL EXA				DATE OF EXAMDATE OF BIRTH			
		% BODY FAT (optional)			20		
		CORRECTED? Y					
VISION R 20/	L 20/	CORRECTED? 1	. IN	PUPILS: EQUAL	UNEQUAL		
	NOE	RMAL ABNORM/	AL EINIG	2010	INITEAL O *		
MEDICAL	NO	RMAL ABNORM/		JING	INITIALS *		
Appearance							
	lose/Throat						
	s						
Heart							
Lungs							
Abdomen_							
	ales only)						
Skin							
MUSCULOSKE	LETAL						
Neck							
Back							
Shoulder/Arı							
	rm						
Wrist/Hand							
Hip/Thigh							
Knee							
Leg/Ankle _							
Foot							
Not cleared	for [Sport(s)]:	ation/rehabilitation for:Rea	ason:				
***************************************			"				
Name of physician/nurse practitioner/physician assistant Address:			(PRII	NT OR TYPE)	Date: Phone:		
		oner/physician assistant					
orginature of priys	scialimuise pracili	onenphysician assistant		PHYSICIANS STA			
Endorsed by the	MPSSAA						

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Pre-Participation Physical Evaluation

HISTORY

This page to be completed by student and parent/guardian



	Name			Sex	x Age Date of Birth			
	Grade School		Sport(s))				
	Address							
	Personal physician							
	In case of emergency, contact							
	Name Relationsh	ip			Phone (H) (W)			
E>	plain "Yes" answers below. Circle questions if you don't kr	ow the	answers.					
		YES	NO	_	YES NO			
1.	Have you had a medical illness or injury since your last check up or sports physical?			10.	Do you use any special protective or corrective equipment or devices that aren't usually used for your sport			
	Do you have an ongoing or chronic illness?				or position (for example, knee brace, special neck roll,			
2.	Have you ever been hospitalized overnight?			4.4	foot orthotics, retainer on your teeth, hearing aid)?			
	Have you ever had surgery?			11.	Have you had any problems with your eyes or vision?			
3.	Are you currently taking any prescription or			40	Do you wear glasses, contacts, or protective eyewear?			
	nonprescription (over-the-counter) medications or pills or using an inhaler?			12.	Have you ever had a sprain, strain, or swelling after injury?			
	Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your				any joints?			
4	performance?				Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?			
4.	medicine, food, or stinging insects)?				If yes, check appropriate box and explain below. ☐ Head ☐ Upper arm ☐ Hand ☐ Knee			
	Have you ever had a rash or hives develop during or after exercise?				☐ Back ☐ Elbow ☐ Finger ☐ Shin/calf ☐ Chest ☐ Forearm ☐ Hip ☐ Ankle			
5.	Have you ever passed out during or after exercise?				☐ Shoulder ☐ Wrist ☐ Thigh ☐ Foot			
	Have you ever been dizzy during or after exercise?			13.	Do you want to weigh more or less than you do now?			
	Have you ever had chest pain during or after exercise?				Do you lose weight regularly to meet weight requirements			
	Do you get tired more quickly than your friends do during exercise?				for your sport? Do you feel stressed out?			
	Have you ever had racing of your heart or skipped heartbeats?		C)		Record the dates of your most recent immunizations (shots) for: Tetanus Measles			
	Have you had high blood pressure or high cholesterol?				Tetanus Measies Hepatitis B Chickenpox			
	Have you ever been told you have a heart murmur?							
	Has any family member or relative died of heart problems or of sudden death before age 50?		O .		IALES ONLY When was your first menstrual period?			
	Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?				When was your most recent menstrual period? How much time do you usually have from the start of one period to the			
	Has a physician ever denied or restricted your participation in sports for any heart problems?				start of another? How many periods have you had in the last year?			
6.	Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?				What was the longest time between periods in			
7.	Have you ever had a head injury or concussion?				the last year?			
	Have you ever been knocked out, become unconscious, or lost your memory?	ō	ā	Expl	lain "Yes" answers here:			
	Have you ever had a seizure?				- 1-17			
	Do you have frequent or severe headaches?	ā	_					
	Have you ever had numbness or tingling in your arms, hands, legs, or feet?	ā	ō					
	Have you ever had a stinger, burner, or pinched nerve?							
8.	Have you ever become ill from exercising in the heat?	ā	ō					
	Do you cough, wheeze, or have trouble breathing during or after activity?	ā	ō					
	Do you have asthma?							
	Do you have seasonal allergies that require medical treatment?	ā	ā					
	We hereby state that, to the best of our knowledge, our answers to the above questions are complete and correct. Signature of athlete Date							