

# Salamanca City Central School District -- Pre-participation Physical Evaluation

Date of Exam: \_\_\_\_\_

Name: \_\_\_\_\_ Sex: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Grade: \_\_\_\_\_ School: \_\_\_\_\_ Sport(s): \_\_\_\_\_

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

Personal Physician: \_\_\_\_\_

*In case of emergency, contact:*

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

1. Have you had a medical illness or injury since your last check up or sports physical? Yes No
  2. Have you ever been hospitalized overnight: Yes No  
Have you ever had surgery? Yes No
  3. Are you currently taking any prescription or nonprescription (over the counter) medications or pills or using an inhaler? Yes No
  4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? Yes No  
Have you ever had a rash or hives develop during or after exercise? Yes No
  5. Have you ever passed out during or after exercise? Yes No  
Have you ever been dizzy during or after exercise? Yes No  
Do you get tired more quickly than your friends do during exercise? Yes No  
Have you ever had chest pain during or after exercise? Yes No  
Have you ever had racing of your heart or skipped heartbeats? Yes No  
Have you had high blood pressure or high cholesterol? Yes No  
Have you ever been told you have a heart murmur? Yes No  
Has any family member or relative died of heart problems or of sudden death before age 60? Yes No  
Have you had a severe viral infection (i.e., myocarditis or mononucleosis) within the last month? Yes No  
Has a physician ever denied or restricted your participation in sports for any heart problems? Yes No
  6. Do you have any current skin problems (i.e., itching, rashes, acne, warts, fungus or blisters)? Yes No
  7. Have you ever had a head injury or concussion? Yes No  
Have you ever been knocked out, become unconscious, or lost your memory? Yes No  
Have you ever had a seizure? Yes No  
Do you have frequent or severe headaches? Yes No  
Have you ever had numbness or tingling in your arms, hands, legs, or feet? Yes No  
Have you ever had a stinger, burner, or pinched nerve? Yes No
  8. Have you ever become ill from exercising in the heat? Yes No
  9. Do you cough, wheeze, or have trouble breathing during or after activity? Yes No  
Do you have asthma? Yes No  
Do you have seasonal allergies that require medical treatment? Yes No
  10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport (i.e., knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? Yes No  
Have you had any problems with your eyes or vision? Yes No
  11. Have you ever had any problems with your eyes or vision? Yes No
  12. Have you ever had a sprain, strain, or swelling after injury? Yes No  
Have you ever broken or fractured any bones or dislocated any joints? Yes No  
Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? Yes No
- If yes, please check appropriate box and explain below:
- |                                    |                                  |                                    |
|------------------------------------|----------------------------------|------------------------------------|
| <input type="checkbox"/> Head      | <input type="checkbox"/> Elbow   | <input type="checkbox"/> Hip       |
| <input type="checkbox"/> Neck      | <input type="checkbox"/> Forearm | <input type="checkbox"/> Thigh     |
| <input type="checkbox"/> Back      | <input type="checkbox"/> Wrist   | <input type="checkbox"/> Knee      |
| <input type="checkbox"/> Chest     | <input type="checkbox"/> Hand    | <input type="checkbox"/> Shin/Calf |
| <input type="checkbox"/> Shoulder  | <input type="checkbox"/> Finger  | <input type="checkbox"/> Ankle     |
| <input type="checkbox"/> Upper Arm |                                  | <input type="checkbox"/> Foot      |
13. Do you want to weigh more or less than you do now? More Less  
Do you lose weight regularly to meet weight requirements for your sport? Yes No
  14. Do you feel stressed out? Yes No

**FEMALES ONLY**

15. When was your first menstrual period? \_\_\_\_\_  
When was your most recent menstrual period? \_\_\_\_\_  
How much time do you usually have from the start of one period to the start of another? \_\_\_\_\_  
How many periods have you had in the past year? \_\_\_\_\_  
What was the longest time between periods in the last year? \_\_\_\_\_  
\_\_\_\_\_.

**I hereby state that, to the best of my knowledge, my answers to the questions are complete and accurate.**

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

\_\_\_\_\_  
Signature of Parent/Guardian

**FOR SCHOOL PHYSICIAN USE ONLY**

This certifies that \_\_\_\_\_ is physically qualified to participate in the following categories of competition during the \_\_\_\_\_ school year.

Any unmarked category indicates disqualification for the particular group of sport activities.

**Contact/Collision**

**Limited Contact / Impact**

**Strenuous/ Non-contact**

**Nonstrenuous/  
Non-contact**

Field Hockey  
Football  
Ice Hockey  
Lacrosse  
Soccer  
Wrestling

Basketball  
Baseball  
Diving  
Gymnastics  
Handball  
Skiing  
Softball  
Volleyball

Crew  
Cross Country  
Track & Field  
Swimming  
Tennis

Archery  
Bowling  
Golf

\_\_\_\_\_  
Date

\_\_\_\_\_  
School/Physician Signature