Rev. 4/10

ARLINGTON CLASSICS ACADEMY

PREPARTICIPATION PHYSICAL EVALUATION -- PHYSICAL EXAMINATION

Student's Name ________________________ Sex _____ Age _____ Entering Grade _____ Date of Birth __________
Height ________Weight _________ Pulse __________BP _____/______ (_____/______,_____/______)
Vision R20/______ L20/________ Corrected: Y N Pupils: Equal ____ Unequal ____

As a minimum requirement, this **Physical Examination Form** must be completed prior to athletic participation. It must be completed if there are yes answers to specific questions on the student's Medical History Form.

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart-Auscultation of the heart in the supine position.			
Heart-Auscultation of the heart in the standing position.			
Heart-Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**	**INITIALS**
Neck			
Back/Spinal Screen			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

CLEARANCE
Cleared
Cleared after completing evaluation/rehabilitation for : ______________________________
Not cleared for: ______________________ Reason: ______________________
Recommendations: ______________________________

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination forms signed by any other health care practitioner will not be accepted.

Printed Name: ______________________ Date of Examination: ______________
Address: ______________________ Phone Number: ______________
Signature: ______________________

Must be completed before a student participates in any practice or games/matches.

PREPARTICIPATION PHYSICAL EVALUATION – MEDICAL HISTORY

This MEDICAL HISTORY FORM must be completed *annually* by parent (or guardian) and student in order for the student to participate in athletic activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an athletic event.

Student's Name: (print) ______________ Sex ________ Age ________ Date of Birth ________

Address ______________________________ Phone ______________ Grade ____

______________ School ______________

Personal Physician ______________________ Phone ______________ *In case of emergency, contact:*

Name ______________ Relationship ______________ Phone (H) ______________ (W) ______________

Explain "Yes" answers in the box below. Circle questions you don't know the answers to.** ***Any Yes answer to questions 1, 2, 3, 4, 5, or 6 requires further medical evaluation which may include a physical examination. Written clearance from a physician, physician assistant, chiropractor, or nurse practitioner is required before any participation in ACA practices, games or matches.***

		Yes	No
	Have you had a medical illness or injury since your last check up or sports physical?	0	0
1.	Have you been hospitalized overnight in the past year?		
	Have you ever had surgery?		
2.	Have you ever passed out during or after exercise?	0	0
	Have you ever had chest pain during or after exercise?	0	0
3.	Do you get tired more quickly than your friends do during exercise?	0	0
	Have you ever had racing of your heart or skipped heartbeats?	0	0
	Have you had high blood pressure or cholesterol?	0	0
	Have you ever been told you have a heart murmur?	0	0
	Has any family member or relative died of heart problems or of sudden unexpected death before age 50?	0	0
	Has any family member been diagnosed with enlarged heart, (dilated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome or other ion channelpathy (Brugada syndrome, etc.), Marfan's syndrome, or abnormal heart rhythm?	0	0
	Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	0	0
	Has a physician ever denied or restricted your participation in sports for any heart problems?	0	0
	Have you ever had a head injury or concussion?	0	0
4.	Have you ever been knocked out, become unconscious, or lost your memory?	0	0
	If yes, how many times? ______	0	0
	When was the last concussion? ______		
	How severe was each one? (Explain below)		
	Have you ever had a seizure?	0	0
	Do you have frequent or severe headaches?	0	0
	Have you ever had numbness or tingling in your arms, hands, legs or feet?	0	0
	Have you ever had a stinger, burner or pinched nerve?	0	0
5.	Are you missing any paired organs?	0	0
6.	Are you under a doctor's care?	0	0
7.	Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?	0	0
8.	Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	0	0
9.	Have you ever been dizzy during or after exercise?	0	0
10.	Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus or blisters)?	0	0
11.	Have you ever become ill from exercising in the heat?	0	0
12.	Have you ever had any problems with your eyes or vision?	0	0
13.	Have you ever gotten unexpectedly short of breath with exercise?	0	0
	Do you have asthma?	0	0
	Do you have seasonal allergies that require medical treatment?	0	0
14.	Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthodontics, retainer on your teeth, hearing aid)?	0	0
15.	Have you ever had a sprain, strain, or swelling after injury?	0	0
	Have you broken or fractured any bones or dislocated any joints?	0	0
	Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?	0	0

If yes, check appropriate box and explain below.

0 Head	0 Elbow	0 Hip
0 Neck 0 Forearm 0 Thigh 0 Back 0 Wrist 0 Knee		
0 Chest	0 Hand	0 Shin/Calf
0 Shoulder	0 Finger	0 Ankle
0 Upper Arm		0 Foot

		Yes	No
16.	Do you want to weigh more or less than you do now?	0	0
	Do you lose weight regularly to meet weight requirements for your sport?	0	0
17.	Do you feel stressed out?	0	0
18.	Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?	0	0

Females Only

19. 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 last year? ________
What was the longest time in between periods in the last year? ________

An individual answering in the affirmative to any question relating to a possible cardiovascular health issue (question 3 above), as identified on the form, should be restricted from further participation until the individual is examined and cleared by a physician, physician assistant, chiropractor, or nurse practitioner.

***** EXPLAIN 'YES' ANSWERS IN THE BOX BELOW** (attach another sheet if necessary):

It is understood that even though protective equipment is worn by the athlete, whenever needed, the possibility of an accident still remains. Neither the league or Arlington Classics Academy assumes any responsibility in case an accident occurs.

If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given said student by any physician, athletic trainer, nurse or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student.

If, between this date and the beginning of athletic competition, any illness or injury should occur that may limit this student's participation, I agree to notify the school authorities of such illness or injury.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Failure to provide truthful responses could subject the student in question to penalties determined by Arlington Classics Academy.

Student Signature ______________ Parent/Guardian Signature ______________ Date ______________

*****THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION INANY PRACTICE, SCRIMMAGE OR CONTEST BEFORE, DURING OR AFTER SCHOOL.**

For School Use Only:

This Medical History Form was reviewed by: Printed Name ______________ Date ______________ Signature ______________