PREPARTICIPATION EVALUATION – HISTORY FORM

Provider keeps on-file; NOT shared with school

(DIRECTIONS: Form is to be filled out by the patient (with parent if minor) prior to appointment. Medical provider should keep form in chart)

Name: _____ Exam Date: _____

Date of Birth: _____ Identified Gender: ☐ Female ☐ Male ☐ Unspecified/Another

Sport(s): _____

List past and current medical conditions: _____

Have you ever had surgery? If yes, list all past surgical procedures: _____

Do you have any allergies? If yes, please list all allergies (i.e., medicines, pollens, food, stinging insects). _____

List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional). _____

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

Condition	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.

GENERAL QUESTIONS	YES	NO
1. Do you have any concerns that you would like to discuss with your provider?	○	○
2. Has a provider ever denied or restricted your participation in sports for any reason?	○	○
3. Do you have any ongoing medical issues or recent illness?	○	○
HEART HEALTH QUESTIONS ABOUT YOU	**YES**	**NO**
4. Have you ever passed out or nearly passed out during or after exercise?	○	○
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	○	○
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?	○	○
7. Has a doctor ever told you that you have any heart problems?	○	○
8. Has a doctor ever requested a test for your heart? (For example, electrocardiography (ECG) or echocardiography.)	○	○
9. Do you get light-headed or feel shorter of breath than your friends during exercise?	○	○
10. Have you ever had a seizure?	○	○
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**YES**	**NO**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?	○	○
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?	○	○
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?	○	○
BONE AND JOINT QUESTIONS	**YES**	**NO**
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?	○	○
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?	○	○
MEDICAL QUESTIONS	**YES**	**NO**
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?	○	○
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?	○	○

MEDICAL QUESTIONS *(Continued)*	YES	NO
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?	○	○
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?	○	○
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?	○	○
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?	○	○
22. Have you ever become ill while exercising in the heat?	○	○
23. Do you or does someone in your family have sickle cell trait or disease?	○	○
24. Have you ever had, or do you have, any problems with your eyes or vision?	○	○
25. Do you worry about your weight?	○	○
26. Are you trying to or has anyone recommended that you gain or lose weight?	○	○
27. Are you on a special diet or do you avoid certain types of foods or food groups?	○	○
28. Have you ever had an eating disorder?	○	○
MENSTRUAL HISTORY ONLY	**YES**	**NO**
29. Have you ever had a menstrual period?	○	○
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

Explain "yes" answers here: _____

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

Athlete's Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____

PREPARTICIPATION EVALUATION – EXAMINATION FORM

Provider keeps on-file; NOT shared with school

(DIRECTIONS: Form is to be filled out by provider and kept in student's medical chart. **Only the Eligibility Form is required for school record/documentation.**)

Name: _____ Date of Birth: _____

PROVIDER REMINDERS

Consider additional questions on more sensitive issues

- Do you feel stressed out or under a lot of pressure?
- Do you ever feel sad, hopeless, depressed, or anxious?
- Do you feel safe at your home or residence?
- Have you ever tried marijuana, cigarettes, e-cigarettes, chewing tobacco, snuff or dip?
- During the past 30 days, did you use any of these?
- Do you drink alcohol or use any other drugs?
- Have you ever taken anabolic steroids or used any other performance supplement?
- Have you ever taken any supplements to help you gain or lose weight or improve your performance?
- Do you wear a seat belt, use a helmet, and use condoms?

EXAMINATION		
Height: Weight:	Vision: R 20/ L 20/	
BP: / (/) Pulse:	Corrected: Yes ◯ No ◯	
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes/Ears/Nose/Throat • Pupils equal • Hearing		
Lymph nodes		
Heart *(Consider ECG, echocardiogram, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.)* • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

Name of Health Care Professional (Print/Type): _____ Date of Exam: _____

Address: _____ Phone: _____

Signature of Health Care Professional: _____, *MD, DO, NP, or PA

*WIAA approved medical providers licensed to perform this exam include a Medical Doctor (MD), Doctor of Osteopathy (DO), Nurse Practitioner (NP), or Physician's Assistant (PA)

PREPARTICIPATION EVALUATION – MEDICAL ELIGIBILITY FORM

RETURN ONLY THIS FORM TO SCHOOL

(DIRECTIONS: Top of form is to be filled out and signed by provider. Provider, return this form following appointment for school record/documentation.)

Name: _____ Date of Birth: _____

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment for: _____

_____

_____

Medically eligible for certain sports:

_____

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations: _____

_____

_____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam findings is on record in my office and can be made available to the school at the request of the parent or guardian. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of Health Care Professional (Print/Type): _____ Date of Exam: _____

Address: _____ Phone: _____

Signature of Health Care Professional: _____, *MD, DO, NP, or PA

**WIAA approved medical providers licensed to perform this exam: Medical Doctor (MD), Doctor of Osteopathy (DO), Nurse Practitioner (NP), and Physician's Assistant (PA)*

SHARED EMERGENCY INFORMATION- ***State law RCW 28A.210.320 requires any student diagnosed with a life-threatening health condition to have current medication(s), medical orders, and a health care plan on file with the school nurse prior to attending school. If you are participating in school-sponsored athletics, contact your school nurse to make sure you have this documentation on file with the school.***

Allergies: _____

_____

Medications: _____

_____

Other Information: _____

_____

_____

(DIRECTIONS: Bottom of form is to be filled out by guardian(s). Guardian, return this completed form following appointment for school record/documentation.)

EMERGENCY CONTACTS

Parent/Guardian #1 Name: _____ Emergency Contact Number: _____

Relationship to Student: _____ Email Address: _____

Parent/Guardian #2 Name: _____ Emergency Contact Number: _____

Relationship to Student: _____ Email Address: _____

Other Emergency Contacts (when Parent/Guardian cannot be reached)

Contact #1 Name: _____ Emergency Contact Number: _____

Relationship to Student: _____ Email Address: _____

Contact #2 Name: _____ Emergency Contact Number: _____

Relationship to Student: _____ Email Address: _____