PREPARTICIPATION PHYSICAL EVALUATION
PHYSICAL EXAMINATION FORM

Name ______________________________ Date of birth ______________

PHYSICIAN REMINDERS

1. 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 cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - 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?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION				
Height	Weight	☐ Male ☐ Female		
BP / (/)	Pulse	Vision R 20/	L 20/	Corrected ☐ Y ☐ N

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for ______________________________

☐ Not cleared

☐ Pending further evaluation

☐ For any sports

☐ For certain sports ______________________________

Reason ______________________________

Recommendations ______________________________

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

Name of physician (print/type) ______________________________ Date ______________

Address ______________________________ Phone ______________

Signature of physician ______________________________ MD or DO/PA/APNP

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PREPARTICIPATION PHYSICAL EVALUATION
CLEARANCE FORM – FORMULARIO DE AUTORIZACIÓN

Asociación Atlética Inter-escolar de Wisconsin – Tarjeta de Permiso Atlético

(Escriba en Imprenta)

TODOS LOS ESTUDIANTES QUE PARTICIPAN EN DEPORTES INTERESCOLARES DEBEN TENER ESTA TARJETA EN ARCHIVO EN SU ESCUELA ANTES DE PRACTICAR O PARTICIPAR

El examen físico tomado 01 de abril ya partir de entonces es válida para los dos años escolares siguientes; examen físico recibido antes del 1 de abril es válida sólo para el resto de ese año escolar y el siguiente año escolar.

Apellido ____________________ Nombre ____________________ (inicial del segundo nombre) _____ Fecha de Nacimiento __________

Edad _____ Sexo _____ Grado _____ Escuela ____________________ Ciudad ____________________

Dirección ____________________ Teléfono ____________________

☐ **Cleared without restriction** ☐ **Cleared, with the following qualifications:** ____________________

____

☐ **Not cleared** ☐ **Pending further evaluation** ☐ **For all sports** ☐ **For certain sports:** ____________________

Reason ____________________

Recommendations ____________________

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

Name of Physician (Print/Type) ____________________

SIGNATURE OF LICENSED PHYSICIAN (MD OR DO)/PA/APNP*: ____________________

Clinic Name ____________________

Address/Clinic ____________________ City ____________________ State _____ Zip Code __________

Telephone ____________________ Date of Examination ____________________

* Physicians may authorize Nurse Practitioners to stamp this card with the physician's signature or the name of the clinic with which the physician is affiliated.

Lugar de Empleo de los Padres ____________________

Médico de la Familia ____________________ Dentista de la Familia ____________________

Nombre de Seguros Privados ____________________ Teléfono ____________________

Nombre de Asegurado Primario ____________________

Información de emergencia

Alergias ____________________

Otra información (medicinas, etc.) ____________________

Inmunizaciones ☐ **Están al día (una copia adjunta)** ☐ **No están al día - especifica** ____________________

(por ejemplo, el tétanos / difteria; paperas sarampión Rubéola; hepatitis A, B; influenza; poliomielitis; neumocócica; meningocócica; varicela)

1. Yo doy mi permiso al estudiante mencionado arriba para practicar y competir y representar a la escuela en WIAA deportes interescolares aprovados, excepto en los restringidos en esta tarjeta.
2. De conformidad con los requisitos de la Portabilidad del Seguro de Salud y la Ley de Responsabilidad de 1996 y los reglamentos promulgados en virtud del mismo (colectivamente conocidos como "HIPAA"), autorizo a los proveedores de salud del estudiante arriba mencionado, incluyendo personal médico de emergencia y otros profesionales igualmente capacitados que pueden debe asistir a un evento o práctica interescolar, a revelar / intercambio de información médica esencial con respecto a la lesión y el tratamiento de este estudiante para el personal del distrito escolar apropiado tal como, pero no limitado a: director, director de Deportes, masajista deportivo, médico del equipo, Entrenador del equipo, Administrativo Asistente del director de Deportes y / u otros proveedores profesionales de atención de salud, a los efectos del tratamiento, la atención de emergencia y lesiones mantenimiento de registros.

Firma del padre/guardián ____________________ Fecha ____________________