



CHINO VALLEY
UNIFIED SCHOOL DISTRICT
Student Achievement • Safe Schools • Positive School Climate
Honesty • Civility • Service

PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex: _____

List past and current medical conditions. _____

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

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

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

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)

	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.)

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

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)	Yes	No	
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	Unsure	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?			

Physical Examination & Medical Eligibility Form

LAST: FIRST: MIDDLE: DATE OF BIRTH: AGE: GRADE: Address: City: Zip: Phone Number:

TO BE COMPLETED BY HEALTH CARE PROFESSIONAL

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, e-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 enhancing 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.

EXAMINATION		
Height:	Weight:	
BP: / (/)	Pulse:	Vision: R 20/ L 20/ Corrected: ☐ Yes ☐ No
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart • Murmurs (auscultation standing, supine, ± Valsalva)		
Lungs		
Abdomen		
Skin • Herpes simplex virus, [HSV], lesions suggestive of MRSA, tinea corporis		
Neurological		
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional (Double-leg squat test, single-leg squat test, box drop, or step drop test)		

Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

ELIGIBILITY STATUS (CHECK ONE):

- ☐ 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 MAY PARTICIPATE IN THE SPORT(S) AS OUTLINED ON THIS FORM. A COPY OF THE PHYSICAL EXAM FINDINGS ARE 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, 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) DATE

SIGNATURE OF HEALTH CARE PROFESSIONAL MD | DO | NP | PA (CIRCLE ONE)

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DATE OF EXAM: / /

PLACE PHYSICIAN'S STAMP HERE

The Medical Eligibility Form is the only form that should be submitted to a school or sports organization.

■ PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

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 of

- ☐ 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 can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are 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, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies: _____

Medications: _____

Other information: _____

Emergency contacts: _____
