



CALVARY CHAPEL CHRISTIAN SCHOOL

Pre-Participation Physical Evaluation

Name: _____ Date of Birth: ____ / ____ / ____

To Be Completed by Physician

Height: _____ Weight: _____ Pulse: _____ BP: _____
Vision: R 20/ _____ L 20/ _____ Corrected: (Circle) Y N Pupils: Equal _____ Unequal _____

Medical	Normal	Abnormal Findings	Initials
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Musculoskeletal			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
Foot			

*Station-based examination only

CLEARANCE

Cleared _____

Cleared after completing evaluation/rehabilitation for: _____

Not cleared for: _____ Reason: _____

Recommendations: _____

Name of Physician (print/type): _____ Phone: (____) _____

Address: _____

Signature of Physician: _____ Date: _____

Pre-Participation Physical Evaluation

To Be Completed by Parent/Athlete

Name: _____ Sex: _____ Age: _____ Date of Birth: ____ / ____ / ____
 Grade: _____ School: _____ Sport(s): _____
 Address: _____ Phone: (____) _____
 Personal Physician: _____
 In Case of Emergency, contact:
 Name: _____ Relationship: _____ Phone: (____) _____ H

Explain "Yes" answers below. Circle questions if not sure.

	Yes	No		Yes	No
1. Have you had a medical illness or injury since your last checkup or sports physical?	_____	_____	Have you ever had numbness or tingling in your arms, hands, legs, or feet?	_____	_____
2. Have you ever been hospitalized overnight?	_____	_____	Have you ever had a stinger , bummer , or pinched nerve?	_____	_____
Have you ever had surgery?	_____	_____	8. Have you ever become ill from exercising in the heat?	_____	_____
3. Are you currently taking any prescription, non-prescription (over-the-counter) medication, or using an inhaler?	_____	_____	9. Do you cough, wheeze, or have trouble breathing during or after activities?	_____	_____
Have you ever taken any supplements or vitamins to help you to gain or lose weight or to improve your performance?	_____	_____	Do you have asthma?	_____	_____
4. Do you have any allergies (e.g., to pollen, medicines, food, or stinging insects)?	_____	_____	Do you have seasonal allergies that require medical treatment?	_____	_____
Have you ever had a rash or hives develop during or after exercise?	_____	_____	10. Do you use any special or corrective equipment or devices that aren't usually used for our sport or position (e.g., knee brace, special neck roll, foot orthotics, retainer on your teeth, or hearing aid)?	_____	_____
5. Have you ever passed out during or after exercise?	_____	_____	11. Have you had any problems with your eyes or vision?	_____	_____
Have you ever been dizzy during or after exercise?	_____	_____	Do you wear glasses, contacts, or protective eyewear?	_____	_____
Have you ever had chest pain during or after exercise?	_____	_____	12. Have you ever had a sprain, strain, or swelling after an injury?	_____	_____
Do you get tired more quickly than your friends during exercise?	_____	_____	Have you broken or fractured any bones or dislocated any joints?	_____	_____
Have you ever had racing of your heart or skipped heartbeats?	_____	_____	Have you ever had any other problems with pain or swelling in muscles, tendons, bones, or joints?	_____	_____
Have you had high blood pressure or high cholesterol?	_____	_____	If yes, check and explain below.		
Have you ever been told you have a heart murmur?	_____	_____	____ Head	____ Elbow	____ Hip
Have any family members or relatives died of heart problems or sudden death before age 80?	_____	_____	____ Neck	____ Forearm	____ Thigh
Have you had a severe viral infection (e.g., myocarditis or mononucleosis) within the last month?	_____	_____	____ Back	____ Wrist	____ Knee
Has a physician ever denied or restricted your participation in sports for any heart problems?	_____	_____	____ Chest	____ Hand	____ Shin/calf
6. Do you have any current skin problems (e.g., itching, rashes, acne, warts, fungus, or blisters)?	_____	_____	____ Shoulder	____ Finger	____ Ankle
7. Have you ever had a head injury or concussion?	_____	_____	____ Upper arm	____ Foot	_____
Have you ever been knocked out, unconscious, or lost your memory?	_____	_____	13. Do you want to weigh more or less than you do now?	_____	_____
Have you ever had a seizure?	_____	_____	Do you lose weight regularly to meet weight requirements for your sport?	_____	_____
Do you have frequent or severe headaches?	_____	_____	14. Do you feel stressed out?	_____	_____
			15. Record the dates of your most recent immunizations for:		
			Tetanus _____ Measles _____		
			Hepatitis B _____ Chickenpox _____		
			Explain "Yes" answers here:		

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

Signature of Athlete

Signature of Parent

____ / ____ / ____
Date