



ACA/Superior Bulldog Athletics

Annual Pre-participation Physical Evaluation

(The Parent or Guardian should fill out this form with assistance from the student athlete.)

Name _____ Sex _____ Age _____ Date of Birth _____ Grade _____

Address _____ Phone _____

In case of emergency, contact: Name: _____

Explain "Yes" answers below. Circle questions you don't know the answer to. Phone (H): _____ (W) _____

Cell Phone: _____

	Yes	No		Yes	No
1. Have you had a medical illness or injury since your last check-up or sports physical? Do you have an ongoing or chronic illness? Are you currently being treated for an injury or condition?	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>
2. Have you ever been hospitalized overnight? Have you ever had surgery?	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler? Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>
4. Do you have any allergies to medications? Do you have any allergies to pollen, food or stinging insects? Have you ever had a rash or hives develop during or after exercise?	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>
5. Have you ever passed out during or after exercise? Have you ever been dizzy during or after exercise? Have you ever had chest pain during or after exercise? Do you get tired more quickly than your friends during exercise? Have you ever had racing of your heart or skipped heartbeats? Have you had high blood pressure or high cholesterol? Have you ever been told you have a heart murmur? Have you had a severe viral infection (i.e., mononucleosis or myocarditis) within the last month? Has a doctor ever denied or restricted your participation in sports for any heart problems? Has anyone in your immediate family had the following conditions? Diabetes _____ Heart disease _____ other _____ Sudden death prior to age 50 _____ High Blood Pressure _____	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>
7. Have you ever had a head injury or concussion? Have you ever been knocked out, become unconscious, or lost your memory? Have you ever had a seizure? Do you have frequent or severe headaches? Have you ever had numbness or tingling in your arms, hands, legs, or feet? Have you ever had a stinger, burner, or pinched nerve?	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>
8. Have you ever become ill from exercising in the heat?	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>
			9. Do you cough, wheeze, or have trouble breathing during or after activity? Do you have asthma? Do you use an inhaler? Do you have seasonal allergies that require medical treatment?	<input type="radio"/>	<input type="radio"/>
			10. 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 orthotics, retainer on your teeth, hearing aid)?	<input type="radio"/>	<input type="radio"/>
			11. Have you had any problems with your eyes or vision? Do you wear glasses, contacts, or protective eyewear?	<input type="radio"/>	<input type="radio"/>
			12. Have you ever had a sprain, strain, or swelling after injury? Have you broken or fractured any bones or dislocated any joints? Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	<input type="radio"/>	<input type="radio"/>
			<i>If yes, check appropriate box below.</i>		
			<input type="radio"/> Head <input type="radio"/> Elbow <input type="radio"/> Hip <input type="radio"/> Neck <input type="radio"/> Forearm <input type="radio"/> Thigh <input type="radio"/> Back <input type="radio"/> Wrist <input type="radio"/> Knee <input type="radio"/> Chest <input type="radio"/> Hand <input type="radio"/> Shin/calf <input type="radio"/> Shoulder <input type="radio"/> Finger <input type="radio"/> Ankle <input type="radio"/> Upper arm <input type="radio"/> Foot		
			13. Do you want to weigh more or less than you do now? Do you lose weight regularly to meet weight requirements for your sport?	<input type="radio"/>	<input type="radio"/>
			14. Do you feel stressed?	<input type="radio"/>	<input type="radio"/>
			15. Do you or have you ever used: Smokeless tobacco _____ Cigarettes _____ Alcohol _____ Recreational drugs _____	<input type="radio"/>	<input type="radio"/>
			Females Only		
			16. 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 between periods in the last year? _____		

Explanation: _____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. I understand and acknowledge that truthful and accurate information is essential in properly determining whether the student should be cleared for athletic participation. I hereby consent for the student named above, to be given medical care by the doctor selected by the school.

Signature of Parent/Guardian _____ Signature of Student Athlete _____ Date _____



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ANNUAL PREPARTICIPATION PHYSICAL EXAMINATION

ANNUAL PHYSICAL EXAMINATION

Name: _____	Date: _____
Height: _____ Weight: _____	Pulse: _____ BP: _____
Vision: R 20/ _____ L 20/ _____ Glasses/Contacts: Yes No Pupils: Equal _____ Unequal _____	

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

*Station-based examination only

CLEARANCE

<input type="checkbox"/> Cleared <input type="checkbox"/> Cleared after completing evaluation/rehabilitation for: _____ _____ _____	
<input type="checkbox"/> Not Cleared for: _____ Reason: _____	
Recommendations: _____ _____	
Name of Physician (print/type) _____ Date _____	
Address _____ Phone _____	
Signature of Physician _____	MD/DO/NP/PA-C