

# ST JOSEPH ACADEMY INC. PRE-PARTICIPATION PHYSICAL EVALUATION

(To be completed by student and parent)

**Part 1. Student Information**

Student's name: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Home Address: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_  
 Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ Pager (\_\_\_\_) \_\_\_\_\_  
 Name of Parent/Guardian: \_\_\_\_\_  
 Person to Contact in Case of Emergency: \_\_\_\_\_  
 Relationship to Student: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_  
 Family Physician: \_\_\_\_\_ City/State: \_\_\_\_\_ Office Phone: (\_\_\_\_) \_\_\_\_\_

**Part 2. Medical History. Explain "yes" answers below. Circle questions if you don't know answer. Include all prescribed medications Rx meds, epeniphrine, allergies, diabetes – carry on person.....**

- |   | YES   | NO    |
|---|-------|-------|
| 1) Date of last full physical exam: ____/____/____ (previous to today's date)   | _____ | _____ |
| 2) Have you had a medical illness or injury since your last check up or sports physical?  | _____ | _____ |
| 3) Do you or anyone in your family have/ had:   |       |       |
| a. heart/vessel disease?  | _____ | _____ |
| b. kidney/ liver problems?  | _____ | _____ |
| c. strokes or CVA's?  | _____ | _____ |
| d. diabetes?  | _____ | _____ |
| e. epilepsy?  | _____ | _____ |
| 4) Are you currently taking any prescription or nonprescription medications or pills or using an inhaler?<br>(include all medications required by student during physical activity i.e. allergy, diabetes, epeniphrine, Rx, etc.) | _____ | _____ |
| 5) Do you have or have you ever had   | YES   | NO    |
| a. an ongoing illness?  | _____ | _____ |
| b. overnight hospitalization?   | _____ | _____ |
| c. surgery?   | _____ | _____ |
| d. any allergies?   | _____ | _____ |
| e. a heart murmur?  | _____ | _____ |
| f. a severe viral infection?  | _____ | _____ |
| g. any current skin problems?   | _____ | _____ |
| h. a seizure?   | _____ | _____ |
| i. frequent or severe headaches?  | _____ | _____ |
| j. asthma?  | _____ | _____ |
| k. problems with eyes or vision?  | _____ | _____ |
| l. racing of your heart or skipped heart beats?   | _____ | _____ |
| m. high blood pressure or high cholesterol?   | _____ | _____ |
| n. a head injury, concussion, lost consciousness,<br>or lost your memory?   | _____ | _____ |
| o. numbness or tingling in your arms, hands, legs or feet?  | _____ | _____ |
| p. a stinger, burner, or pinched nerve?   | _____ | _____ |
| q. difficulty with exercising in the heat?  | _____ | _____ |
| r. a sprain, strain, or swelling after injury?  | _____ | _____ |
| s. any broken or fractured bones or dislocated joints?  | _____ | _____ |
| t. any other problems with pain or swelling in muscles, bones,<br>tendons, or joints?   | _____ | _____ |
| 6) During or after exercise, do you or have you ever:   |       |       |
| a. been dizzy or passed out?  | _____ | _____ |
| b. had chest pain?  | _____ | _____ |
| c. cough, wheeze, or have trouble breathing?  | _____ | _____ |
| d. tire more quickly than your friends do?  | _____ | _____ |
| 7) Has a physician ever denied or restricted your participation in sports for any heart problems?   | _____ | _____ |
| 8) Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position ( i.e. knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?           | _____ | _____ |
| 9) Do you have any unusual reactions to heat or cold?   | _____ | _____ |
| 10) Do you lose weight regularly to meet weight requirements for your sport?  | _____ | _____ |
| <b>MALES ONLY</b>   |       |       |
| 11) Have you had testicular surgery or only have one testicle   | _____ | _____ |

Explain "yes" answers here. (Please place # from above first, then explain):

We hereby state, to the best of our knowledge, that our answers to the above questions are complete and correct. In addition to the routine medical evaluation required by s.1006.20, Florida Statutes, and FHSAA Bylaw 11.8, we understand and acknowledge that we are hereby advised that the student should undergo a cardiovascular assessment, which may include such diagnostic tests as electrocardiogram (EKG), echocardiogram (ECG) and/or cardio stress test.

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



*Physicals are only valid for 365 days*

**PHYSICAL EXAM  
2009 – 2010**

Student Name \_\_\_\_\_

<b>Height (inches)</b>	<u>          </u>	<b>HEENT</b>	<b>WNL</b>	<b>ABN</b>
<b>Weight (pounds)</b>	<u>          </u>	<b>Neck</b>	<u>          </u>	<u>          </u>
<b>Blood pressure</b>	<u>          </u>	<b>Lungs</b>	<u>          </u>	<u>          </u>
<b>Pulse</b>	<u>          </u>	<b>Heart</b>	<u>          </u>	<u>          </u>
<b>Vision</b>		<b>Abdomen</b>	<u>          </u>	<u>          </u>
<b>Right eye</b>	20/ <u>        </u>	<b>Genitals</b>	<u>          </u>	<u>          </u>
<b>Left eye</b>	20/ <u>        </u>	<b>Skin</b>	<u>          </u>	<u>          </u>
<b>Contacts/glasses</b>	Yes    No	<b>Appearance</b>	<u>          </u>	<u>          </u>
<b>Pupils</b>	Equal   Unequal			

	<b>WNL</b>	<b>ABN</b>		<b>WNL</b>	<b>ABN</b>
<b>Neck</b>	<u>          </u>	<u>          </u>	<b>Knee</b>	<u>          </u>	<u>          </u>
<b>Spine</b>	<u>          </u>	<u>          </u>	<b>MCL</b>	<u>          </u>	<u>          </u>
<b>Shoulder</b>	<u>          </u>	<u>          </u>	<b>LCL</b>	<u>          </u>	<u>          </u>
<b>Stability</b>	<u>          </u>	<u>          </u>	<b>ACL</b>	<u>          </u>	<u>          </u>
<b>Alignment</b>	<u>          </u>	<u>          </u>	<b>PCL</b>	<u>          </u>	<u>          </u>
<b>Elbow/Forearm</b>	<u>          </u>	<u>          </u>	<b>Meniscus</b>	<u>          </u>	<u>          </u>
<b>Wrist Hand</b>	<u>          </u>	<u>          </u>	<b>Patella</b>	<u>          </u>	<u>          </u>
<b>Hip/Thigh</b>	<u>          </u>	<u>          </u>	<b>Pain</b>	<u>          </u>	<u>          </u>
<b>Ankle</b>	<u>          </u>	<u>          </u>	<b>Apprehension</b>	<u>          </u>	<u>          </u>
<b>Stability</b>	<u>          </u>	<u>          </u>	<b>Crepitation</b>	<u>          </u>	<u>          </u>
<b>Alignment</b>	<u>          </u>	<u>          </u>	<b>Functional Test</b>	<u>          </u>	<u>          </u>
<b>Feet</b>	<u>          </u>	<u>          </u>	<b>One Leg Hop</b>	<u>          </u>	<u>          </u>
			<b>Full Squats</b>	<u>          </u>	<u>          </u>

**Cleared for Participation**      \_\_\_ **YES**                      \_\_\_ **NO**

**COMMENTS:**

**Physician's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_