



■ 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: _____

Supplemental COVID-19 questions

1. Have you had any of the following symptoms in the past 14 days?
 - a) Fever or chills Yes / No
 - b) Cough Yes / No
 - c) Shortness of breath or difficulty breathing Yes / No
 - d) Fatigue Yes / No
 - e) Muscle or body aches Yes / No
 - f) Headache Yes / No
 - g) New loss of taste or smell Yes / No
 - h) Sore throat Yes / No
 - i) Congestion or runny nose Yes / No
 - j) Nausea or vomiting Yes / No
 - k) Diarrhea Yes / No
 - l) Date symptoms started _____
 - m) Date symptoms resolved _____
2. Have you ever had a positive test for COVID-19? Yes / No
 - If yes:
 - i. Date of test _____
 - ii. Were you tested because you had symptoms? Yes / No
 - If yes:
 - a) Date symptoms started _____
 - b) Date symptoms resolved _____
 - c) Were you hospitalized? Yes / No
 - d) Did you have fever > 100.4 F.? Yes / No
 - If yes, how many days did your fever last? _____
 - e) Did you have muscle aches, chills, or lethargy? Yes / No
 - If yes, how many days did these symptoms last? _____
 - f) Have you had the vaccine? Yes / No
 - iii. Were you tested because you were exposed to someone with COVID-19, but you did not have any symptoms? Yes / No
 3. Has anyone living in your household had any of the following symptoms or tested positive for COVID-19 in the past 14 days? Yes / No
 - If Yes, circle the applicable symptoms.
 - Fever or chills
 - Muscle or body aches
 - Nausea or vomiting
 - Sore throat
 - Shortness of breath or difficulty breathing
 - New loss of taste or smell
 - Congestion or runny nose
 - Fatigue
 - Diarrhea
 - Headache
 - Cough
 4. Have you been within 6 feet for more than 15 minutes of someone with COVID-19 in the past 14 days? Yes / No
 - If yes: date(s) of exposure _____
 5. Are you currently waiting on results from a recent COVID test? Yes / No

Sources:

- [Interim Guidance on the Preparticipation Physical Examination... : Clinical Journal of Sport Medicine \(lww.com\)](#)
- [Supplemental COVID-19 Questions \(lww.com\)](#)
- [COVID-19 Interim Guidance: Return to Sports and Physical Activity \(aap.org\)](#)



■ PREPARTICIPATION PHYSICAL EVALUATION

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 assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, or other): _____

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 (ie, 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	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?		



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PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

PHYSICIAN REMINDERS

- 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?
 - 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?
- Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: _____	Weight: _____	
BP: _____ / _____ (_____ / _____)	Pulse: _____	Vision: R 20/ _____ L 20/ _____ Corrected: ☐ Y ☐ N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat - Pupils equal - Hearing		
Lymph nodes		
Heart ^a Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional Double-leg squat test, single-leg squat test, and box drop or step drop test		

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

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

Address: _____ Phone: _____

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