El Camino Real Charter High School
Pre-Participation Physical Evaluation

Date of Exam:_____ Appendix A

Student's name:_____ Sex:_____ Age:_____ Date of Birth:_____
Grade:_____ School:_____ Sport(s):_____
Address:_____ Phone:_____
Personal Physician/Provider:_____
In case of emergency, contact: Name:_____ Relationship:_____
Phone (H):_____ (W):_____ (Cell):_____ (Cell):_____

Medicines: Please list all the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging insects

This section is to be carefully completed by the student and his/her parent(s) or legal guardian(s) before participation in interscholastic athletics. Explain yes answers below.

General Questions	Yes	No	Medical Questions	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason? If so, When? _____			26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
2. Do you have any ongoing medical conditions? If so, please identify below: Asthma Anemia Diabetes Infections Other:_____			27. Are you **currently** using an inhaler or taken asthma medicine?		
3. Have you ever spent the night in a hospital? Date:_____			28. Is there anyone in your family who has asthma?		
4. Have you ever had surgery? Date:_____			29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**	30. Do you have groin pain or a painful bulge or hernia in the groin area?		
5. Have you ever passed out or nearly passed out DURING or AFTER exercise? If Yes, Why?			31. Have you had infectious mononucleosis (mono) within the last month?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			32. Do you have any rashes, pressure sores, or other skin problems?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?			33. Have you had a herpes or MRSA skin infection?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ Kawasaki disease ☐ A Heart Infection ☐ High Blood Pressure ☐ A Heart Murmur ☐ High Cholesterol ☐ Other:_____			34. Have you ever had a head injury or concussion? If so, when? _____		
9. Has a doctor ever ordered a test for your heart (for example, ECG/EKG, echocardiogram)? If so, Results:			35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
10. Do you get lightheaded or feel more short of breath than expected during exercise?			36. Do you have a history of seizure disorder?		
11. Have you ever had an unexplained seizure? If so, Date of last seizure:			37. Do you have headaches with exercise?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?			38. Have you ever had numbness, tingling, or weakness in your arms or legs after Being hit or falling?		
HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**	39. Have you ever been unable to move your arms or legs after being hit or falling?		
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome?)			40. Have you ever become ill while exercising in the heat?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrythmogenic right ventricular cardiomyopathy, long Qt syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardis?			41. Do you get frequent muscle cramps when exercising?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			42. Do you or someone in your family have sickle cell trait or disease?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			43. Have you had any problems with your eyes or vision?		
BONE AND JOINT QUESTIONS			44. Have you had any eye injuries?		
17. Have you **recently** had an injury, like a sprain, muscle, or ligament tear, or tendinitis that caused you to miss a practice or game?			45. Do you wear glasses or contact lenses?		
18. Do you currently have any broken bones or dislocated joints?			46. Do you wear protective eyewear, such as goggles or a face shield?		
19. Have you ever had an injury that required X-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?			47. Do you worry about your weight?		
20. Have you ever had a stress fracture?			48. Are you trying to or has anyone recommended that you gain or lose weight?		
21. Have you been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)			49. Are you on a special diet or do you avoid certain types of food?		
22. Do you regularly use a brace, orthotics or other assistive device?			50. Have you ever had an eating disorder?		
23. Do you have a bone, muscle, or joint injury that bothers you?			51. Do you have any concerns that you would like to discuss with a doctor?		
24. Do any of your joints become painful, swollen, feel warm, or look red?			**FEMALES ONLY**		
25. Do you have any history of juvenile arthritis or connective tissue disease?			52. Have you ever had a menstrual period?		
			53. How old were you when you had your first menstrual period? _____		
			54. How many periods have you had in the last 12 months? _____		
List any Past Medical Issues that we should know about here: _____ _____			Explain "yes" answer here: _____ _____		

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

Signature of athlete_____ Signature of parent/guardian_____ Date _____

Modified from American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Orthopedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine 2010

No Faxes or copies will be accepted. All signatures and marks need to be original.

Physical Evaluation must be completed by a MD, DO, NP, PA and must *include Doctor's stamp*

Please visit www.ecrchs.net for more information.

All original physical forms will be filed with the ECRCHS Health Office

Physical Examination Form

The section below is to be completed by physician or staff after history and consent forms are completed **Appendix A**

Students Name:_____ **DOB:**_____

Height:_____ **Weight:**_____ **%BMI (optional)**_____ **Pulse:**_____ **BP:**_____/_____ (_____/_____ _____/_____)

Vision: R 20/_____ **L 20/**_____ **Corrected: Y N Pupils: Equal**_____ **Unequal**_____

EMERGENCY INFORMATION

Allergies:_____

Other information:_____

Medical	Normal	Abnormal Findings
Appearance • Marfan stigmata (kyphoscollosis, high arched palate, pectus excavatum, arachnodactyly, arm span> height, hyperfaxity, myopia, MVP, aortic insufficiency		
Eyes/ Ears/ Nose/ Throat • Pupils equal • Hearing		
Lymph Nodes		
Heart • Murmurs (auscultation standing. Supine +/- Valsava) • Location of point of maximal impulse (PMI)		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		
Functional • Duck walk, single leg hop		

Consider ECG echocindogram and referral to cardiology for abnormal cardiac history or exam
Consider GU exam if in private seating. Having 3rd party present is recommended
Consider cognitive evaluation or baseline neuropsychiatric setting of a history of significant concussion

Clearance

Cleared for all sports without restriction
Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____
Not cleared
☐ Pending further evaluation
☐ For any sport
☐ For certain sports _____

Reason/Recommendations_____

I have evaluated the above named student and completed the pre-participation physical evaluation. The athlete does not present apparent contraindications to practice, tryout and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parent. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians)

Name of Physician/Provider: (print/type/stamp)_____ (MD, DO, NP, or PA) Date:_____

Address:_____ Phone:_____

Signature of Physician/Provider:_____

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