



Archdiocese of Miami
 Department of Schools
Athletic Pre-participation Physical Evaluation (Page 1 of 2)
 This completed form must be kept on file by the school

Part 1. Student information (to be completed by the parent).

Student Name: _____ Sex: _____ Age _____ Date of Birth _____ / _____ / _____
 School: _____ Grade in School _____ Sport(s) expected to play _____
 Home Address: _____ Home Phone () _____
 Name of Parent/Guardian: _____
 Person to Contact in Case of Emergency: _____
 Relationship to Student: _____ Home Phone: () _____ Work Phone: () _____
 Personal Family Physician: _____ City/State: _____ Office Phone: () _____

Part 2. Medical History (to be completed by parent). Explain "yes" answers below. Circle questions for which you do not know the answer

- | | Yes | No | | Yes | No |
|------------------------------------------------------------------------------------------------------------------------------|-------|-------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|---------------|
| 1. Has child had a medical illness or injury since the last check up or sports physical? | _____ | _____ | 26. Has child ever become ill from exercising in the heat? | _____ | _____ |
| 2. Does child have an ongoing chronic illness? | _____ | _____ | 27. Does child cough, wheeze or have trouble breathing during or after activity? | _____ | _____ |
| 3. Has child ever been hospitalized overnight? | _____ | _____ | 28. Does child have asthma? | _____ | _____ |
| 4. Has child ever had surgery? | _____ | _____ | 29. Does child have seasonal allergies that require medical treatment? | _____ | _____ |
| 5. Is child currently taking any prescription or nonprescription (over the counter) medications or pill or using an inhaler? | _____ | _____ | 30. Does child have 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)? | _____ | _____ |
| 6. Has child ever taken any supplements or vitamins to help gain or lose weight or improve performance? | _____ | _____ | 31. Has child had any problems with his/her eyes or vision? | _____ | _____ |
| 7. Does child have any allergies (for example to pollen, medicine, food or stinging insects)? | _____ | _____ | 32. Does child wear glasses, contacts, or protective eye wear? | _____ | _____ |
| 8. Has child ever had rash or hives develop during or after exercise? | _____ | _____ | 33. Has child ever had a sprain, strain, or swelling after injury? | _____ | _____ |
| 9. Has child ever passed out during or after exercise? | _____ | _____ | 34. Has child broken or fractured any bones or dislocated any joints? | _____ | _____ |
| 10. Has child ever been dizzy during or after exercise? | _____ | _____ | 35. Has child had any other problems with pain or swelling in muscles, tendons, bones, or joints? | _____ | _____ |
| 11. Has child ever had chest pain during or after exercise? | _____ | _____ | <i>If yes, check appropriate blank and explain below:</i> | | |
| 12. Does child get tired more quickly than friends during exercise? | _____ | _____ | ___ Head | ___ Elbow | ___ Hip |
| 13. Has child ever had racing of the heart or skipped heartbeats? | _____ | _____ | ___ Neck | ___ Forearm | ___ Thigh |
| 14. Has child had high blood pressure or high cholesterol? | _____ | _____ | ___ Back | ___ Wrist | ___ Knee |
| 15. Has child ever been told he/she has a heart murmur? | _____ | _____ | ___ Chest | ___ Hand | ___ Shin/Calf |
| 16. Has any family member or relative died of heart problems or sudden death before age 50? | _____ | _____ | ___ Shoulder | ___ Finger | ___ Ankle |
| 17. Has child had severe viral infection (for example, myocarditis or mononucleosis) within the last month? | _____ | _____ | ___ Upper Arm | ___ Foot | |
| 18. Has a physician ever denied or restricted child's participation in sports for any heart problems? | _____ | _____ | 36. Does child want to weigh more or less than child weighs now? | _____ | _____ |
| 19. Does child have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? | _____ | _____ | 37. Does child lose weight regularly to meet weight requirements for a sport? | _____ | _____ |
| 20. Has child ever had a head injury or concussion? | _____ | _____ | 38. Does child feel stressed out? | _____ | _____ |
| 21. Has child ever been knocked out, become unconscious, or lost his/her memory? | _____ | _____ | 39. Record the dates of his/most recent immunizations (shots) for: | | |
| 22. Has child ever had a seizure? | _____ | _____ | Tetanus _____ Measles: _____ | | |
| 23. Does child have frequent or severe headaches? | _____ | _____ | Hepatitis B _____ Chickenpox: _____ | | |
| 24. Has child ever had numbness or tingling in his/her arms, hands, legs, or feet? | _____ | _____ | | | |
| 25. Has child ever had a stinger, burner, or pinched nerve? | _____ | _____ | | | |

Explain "Yes" answers here: _____

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

Signature of Parent/Guardian _____ Date: _____