



WALLINGFORD PUBLIC SCHOOLS
PREPARTICIPATION PHYSICAL EVALUATION FORM

History Form (Note: This portion is to be filled out by the student-athlete and parent.)

Name _____ Date of Birth _____

Sex _____ Age _____ Grade _____ School _____

Sport(s) _____, _____, _____

Explain "YES" answers below:	Yes	NO
1. Have you ever been hospitalized? Have you ever had surgery?	_____ _____	_____ _____
2. Are you presently taking any medications or pills?	_____	_____
3. Do you have any allergies? If yes, please identify allergy: ☐ Food ☐ Medicines ☐ Pollens ☐ Stinging Insects	_____	_____
4. 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 tire more quickly than your friends during exercise? Have you ever had high blood pressure? Have you ever been told that you have a heart murmur? Have you ever had racing of your heart or skipped heartbeats? Has anyone in your family died of heart problems or a sudden death before age 50?	_____ _____ _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____ _____
5. Do you have any skin problems (itching, rashes, and acne)?	_____	_____
6. Have you ever had a head injury? Have you ever been knocked out or unconscious? Have you ever had a seizure? Have you ever had a stinger, burn or pinched nerve?	_____ _____ _____ _____	_____ _____ _____ _____
7. Have you ever had heat or muscle cramps? Have you ever been dizzy or passed out in the heat?	_____ _____	_____ _____
8. Do you have trouble breathing or do you cough during or after activity?	_____	_____
9. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)?	_____	_____
10. Have you had any problems with your eyes or vision? Do you wear glasses or contacts or protective eyewear?	_____ _____	_____ _____
11. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints? If yes, check <u>all</u> that apply: ____ Head ____ Shoulder ____ Thigh ____ Neck ____ Elbow ____ Knee ____ Chest ____ Forearm ____ Shin/Calf ____ Back ____ Wrist ____ Ankle ____ Hip ____ Hand ____ Foot	_____	_____
12. Have you had any other medical problems (infectious, mononucleosis, diabetes, etc.)?	_____	_____
13. Have you had a medical problem or injury since your last evaluation?	_____	_____

14. When was your last tetanus shot? _____ When was your last measles immunization? _____

15. When was your first menstrual period? _____ When was your last menstrual period? _____

What was the longest time between your periods last year? _____

Explain "Yes" answer(s) _____

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

Signature of Parent/Guardian _____ **Date** _____

Signature of Student/Athlete _____ **Date** _____

WALLINGFORD PUBLIC SCHOOLS
PREPARTICIPATION PHYSICAL EVALUATION FORM (continued)

Physical Examination (Note: This portion is to be filled out by your physician.)

Name _____ Age _____ Date of Birth _____

Date of Exam _____

Height _____	Weight _____	BP _____ / _____	Pulse _____
Vision R20/ _____	L20/ _____	Corrected: Y N	Pupils _____
	NORMAL	ABNORMAL FINDINGS	INITIALS
Cardiopulmonary			
Pulses			
Heart			
Lungs			
Tanner Stage	1	2 3 4 5	
Skin			
Abdominal			
Genitalia			
Musculoskeletal			
Neck			
Shoulder			
Elbow			
Wrist			
Hand			
Back			
Knee			
Ankle			
Foot			
Other			

Clearance:

A. Cleared

B. Cleared after completing evaluation/rehabilitation for: _____

C. Not Cleared for: _____ Collision _____ Contact _____ Non-Contact _____ Strenuous _____
 _____ Moderately Strenuous _____ Non-Strenuous

Due to _____

Recommendation _____

Name of Physician (PRINT) _____ Date _____

Physician Address _____ Phone _____

Signature of Physician _____