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Disclaimer: Athletes who have a current Preparticipation Physical Evaluation (per state and local guidance) on file should not need to complete another History Form.

## ■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

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Note: Complete and sign this form (with your parent			pointment. Ite of birth:	
Name: Date of examination:				
Sex assigned at birth (F, M, or intersex):				ner gender):
Have you had COVID-19? (check one): □ Y □	N			
Have you been immunized for COVID-19? (check	one): □Y □N		u had: □ One shot □ □ Booster date(s)	
List past and current medical conditions.				
Have you ever had surgery? If yes, list all past surgi	cal procedures.			
Medicines and supplements: List all current prescri	ptions, over-the-cou	unter medicines, a	nd supplements (herbal	and nutritional).
Do you have any allergies? If yes, please list all yo	our allergies (ie, me	dicines, pollens, fo	ood, stinging insects).	
Patient Health Questionnaire Version 4 (PHQ-4)				
Over the last 2 weeks, how often have you been b				
	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 [question:	s 1 and 2, or ques	tions 3 and 4] for scree	ening purposes.)

(Ехр	IERAL QUESTIONS lain "Yes" answers at the end of this form. Circle stions 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?		
HEA	RT 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.		

	, 1	<u>' '</u>		
	ART HEALTH QUESTIONS ABOUT YOU INTINUED)		Yes	No
9.	Do you get light-headed or feel shorter of breathan your friends during exercise?	ıth		
10.	Have you ever had a seizure?			
HEA	RT HEALTH QUESTIONS ABOUT YOUR FAMILY	Unsure	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?			

O	NE AND JOINT QUESTIONS	Yes	No	MEDIC	CAL QUESTIONS (CONTINUED)	
4.	Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?			26. A	Do you worry about your weight? Are you trying to or has anyone recommend you gain or lose weight?	ded that
15.	Do you have a bone, muscle, ligament, or joint injury that bothers you?			27. A	Are you on a special diet or do you avoid c ypes of foods or food groups?	ertain
MEI	DICAL QUESTIONS	Yes	No	28. F	lave you ever had an eating disorder?	
16.	Do you cough, wheeze, or have difficulty breathing during or after exercise?				TRUAL QUESTIONS  tave you ever had a menstrual period?	N/A
17.	Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?			30. F	How old were you when you had your first to period?	menstrual
18.	Do you have groin or testicle pain or a painful bulge or hernia in the groin area?				When was your most recent menstrual perion How many periods have you had in the pas	
19.	Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)?			m	n "Yes" answers here.	
20.	Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?					
21.	Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?					
22.	Have you ever become ill while exercising in the heat?					
23.	Do you or does someone in your family have sickle cell trait or disease?					
	Have you ever had or do you have any problems					

Yes No

Yes No

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Signature of athlete: \_\_

Date: \_\_\_\_\_

Signature of parent or guardian:

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## PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

## PHYSICAL EXAMINATION FORM

tinea corporis

Name:	Date of bir	th:	
PHYSICIAN REMINDERS  1. 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?  • Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?  • 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-enhancie  • Have you ever taken any supplements to help you gain or lose weight or impro  • Do you wear a seat belt, use a helmet, and use condoms?  2. Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Fo	ve your performance?		
EXAMINATION			
Height: Weight:			
BP: / ( / ) Pulse: Vision: R 20/	L 20/ Correc	ted: 🗆 Y 🏻	□N
COVID-19 VACCINE			
Previously received COVID-19 vaccine: □ Y □ N			
Administered COVID-19 vaccine at this visit: □ Y □ N If yes: □ First dose □ So	econd dose 🗆 Third d	ose 🗆 Boost	er date(s)
MEDICAL		NORMAL	ABNORMAL FINDINGS
Appearance     Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnod myopia, mitral valve prolapse [MVP], and aortic insufficiency)	actyly, hyperlaxity,		
Eyes, ears, nose, and throat  Pupils equal  Hearing			
Lymph nodes			
Heart <sup>a</sup> • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)			
Lungs			
Abdomen			
Skin			

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 combi-

Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant Staphylococcus aureus (MRSA), or

 The Medical Eligibility Form is the only form that should be submitted to a school or sports organization.

## ■ PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM		
Name:	Date of birth:	
$\hfill\Box$ Medically eligible for all sports without restriction		
□ Medically eligible for all sports without restriction with recom	nmendations 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 co apparent clinical contraindications to practice and can pa examination findings are on record in my office and can arise after the athlete has been cleared for participation, and the potential consequences are completely explained	articipate in the sport(s) as outlined on this form be made available to the school at the request of the physician may rescind the medical eligibility	n. A copy of the p hysical of the parents. If c onditions
and the potential consequences are completely explained	a to the atmete (and parents of guardians).	
Name of health care professional (print or type):		
Name of health care professional (print or type):	Date:	
	Date:	404-446-4726
Name of health care professional (print or type):  Address: Intown Pediatric & Adolescent Medicine, 490	Date:	404-446-4726
Name of health care professional (print or type):  Address: Intown Pediatric & Adolescent Medicine, 490  Signature of health care professional:	Date: Date: Date: Date:	404-446-4726
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Name of health care professional (print or type):  Address: Intown Pediatric & Adolescent Medicine, 490 Signature of health care professional:  SHARED EMERGENCY INFORMATION Allergies:	Date: Date: Date: Date:	404-446-4726
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Name of health care professional (print or type):  Address: Intown Pediatric & Adolescent Medicine, 490 Signature of health care professional:  SHARED EMERGENCY INFORMATION  Allergies:  Medications:	Date: Date: Date: Date:	404-446-4726
Name of health care professional (print or type):  Address: Intown Pediatric & Adolescent Medicine, 490 Signature of health care professional:  SHARED EMERGENCY INFORMATION  Allergies:  Medications:  Other information:	Date: Dill Kennedy Way Atlanta GA 30316 Phone:	404-446-4726
Name of health care professional (print or type):  Address: Intown Pediatric & Adolescent Medicine, 490 Signature of health care professional:  SHARED EMERGENCY INFORMATION  Allergies:  Medications:	Date: Dill Kennedy Way Atlanta GA 30316 Phone:	404-446-4726

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