Rolling Hills Prep School
Physical Evaluation

Date of Exam: _____

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): _____

History

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

		Yes	No
1.	Do you think you are in good health?	☐	☐
2.	Do you have an ongoing medical condition (like diabetes or asthma)?	☐	☐
3.	Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	☐	☐
4.	Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐
5.	Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
6.	Have you ever passed out or nearly passed out DURING exercise?	☐	☐
7.	Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
8.	Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
9.	Does your heart race or skip beats during exercise?	☐	☐
10.	Has a doctor ever told you that you have (circle all that apply): High Blood Pressure A Heart Murmur High Cholesterol A Heart Infection	☐	☐
11.	Has a doctor ever ordered a test for your heart (for example, ECG, echocardiogram)?	☐	☐
12.	Has anyone in your family died for no apparent reason?	☐	☐
13.	Does anyone in your family have a heart problem?	☐	☐
14.	Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
15.	Does anyone in your family have Marfan syndrome?	☐	☐
16.	Have you ever spent the night in a hospital?	☐	☐
17.	Have you ever had surgery?	☐	☐
18.	Have your ever had an injury, like a sprain, muscle, or ligament tear, or tendinitis that caused you to miss a practice or game? If yes, circle affected area below:	☐	☐
19.	Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	☐	☐
20.	Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:	☐	☐
	Head Neck Shoulder Upper Arm Elbow Chest Hand/Fingers Forearm Ankle Foot/Toes Upper Back Lower Back Hip Thigh Knee Calf/Shin		
21.	Have you ever had a stress fracture?	☐	☐
22.	Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
23.	Do you regularly use a brace or assistive device?	☐	☐
24.	Has a doctor ever told you that you have asthma or allergies?	☐	☐

		Yes	No
25.	Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
26.	Is there anyone in your family who has asthma?	☐	☐
27.	Have you ever used an inhaler or taken asthma medicine?	☐	☐
28.	Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
29.	Have you had infectious mononucleosis (mono) within the last month?	☐	☐
30.	Do you have any rashes, pressure sores, or other skin problems?	☐	☐
31.	Have you had a herpes skin infection?	☐	☐
32.	Have you had any problems with your eyes or vision?	☐	☐
33.	Do you wear glasses or contact lenses?	☐	☐
34.	Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
35.	Are you happy with your weight?	☐	☐
36.	Are you trying to gain or lose weight?	☐	☐
37.	Has anyone recommended you change your weight or eating habits?	☐	☐
38.	Do you limit or carefully control what you eat?	☐	☐
39.	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
40.	Have you ever had a head injury or concussion?	☐	☐
41.	Have you been hit in the head and been confused or lost your memory?	☐	☐
42.	Have you ever had a seizure?	☐	☐
43.	Do you have headaches with exercise?	☐	☐
44.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
45.	Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
46.	When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
47.	Do you have any concerns that you would like to discuss with a doctor?	☐	☐

FEMALES ONLY

48.	Have you ever had a menstrual period?	☐	☐
49.	How old were you when you had your first menstrual period?		
50.	How many period have you had in the last 12 months?		

Explain "Yes" Answers Here: (Attach additional sheets as needed)

_____

_____

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

Signature: _____ (Athlete) Signature: _____ (Parent or Guardian) Date: _____

Physical Examination Form

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

Student's 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	Initials*
Appearance			
Eyes/ Ears/ Nose/ Throat			
Hearing			
Lymph Nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/ Arm			
Elbow/ Forearm			
Wrist/ Hand/ Fingers			
Hip/ Thigh			
Knee			
Leg/ Ankle			
Foot/ Toes			

*Multiple-examiner set-up only.

Notes: _____

Clearance

☐ Cleared without restriction

☐ Cleared, with recommendations for further evaluation or treatment for: _____

☐ Not cleared for: ☐ All Sports ☐ Certain Sports:

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

Address: _____ Phone: _____

Signature of Physician/ Provider: _____

Modified from American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine, 2004.