

\_\_\_\_\_ Private Medical Doctor  
\_\_\_\_\_ School Physician

Physical Education Period \_\_\_\_\_

**CLARENCE CENTRAL SCHOOL  
SPORTS PREPARTICIPATION EVALUATION**

NAME \_\_\_\_\_ DATE \_\_\_\_\_ GRADE \_\_\_\_\_

(To be completed by athlete and parent)

- |   | <u>YES</u> | <u>NO</u> |
|---|------------|-----------|
| 1. Have any members of your family under 50 had a "heart attack" or "heart problem"? (Parents, Grandparents, Aunts, Uncles)             | _____      | _____     |
| 2. Have you ever been told you had a heart murmur, high blood pressure, extra heart beats, or a heart abnormality?                      | _____      | _____     |
| 3. Do you have to stop while running around a (1/4 mile) track twice?   | _____      | _____     |
| 4. Do you have any defect, disability or chronic illness?   | _____      | _____     |
| 5. Are you taking any medications?  | _____      | _____     |
| 6. Have you ever "passed out" or been "knocked out" (concussion)?   | _____      | _____     |
| a.) Passed out while exercising?  | _____      | _____     |
| b.) Had a concussion within the past year?  | _____      | _____     |
| 7. Do you have any problems with your menstrual period?   | _____      | _____     |
| 8. Have you ever had any illness, condition, or injury that:  |            |           |
| a.) required you to go to the hospital either as a patient overnight or in the emergency room or for x-rays?                            | _____      | _____     |
| b.) required an operation?  | _____      | _____     |
| c.) lasted longer than a week?  | _____      | _____     |
| d.) caused you to miss a game or practice?  | _____      | _____     |
| e.) is related to allergies (hay fever, hives, asthma, or medication)?  | _____      | _____     |
| 9. Do you have any problems relating to growth, development or nutrition with which your teachers or coaches should be acquainted with? | _____      | _____     |
| 10. Are you physically able to participate in athletics?  | _____      | _____     |

For any "Yes" answers to the above questions, please provide additional information including date of occurrence on the lines below:

---

---

Parent's Signature: \_\_\_\_\_

Name \_\_\_\_\_

### PHYSICAL EXAMINATION

The physical examination must be completed by a licensed physician who is authorized to practice medicine in New York State or by a mid level practitioner working in collaboration with the physician.

Urine Sugar \_\_\_\_\_ Protein \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

- I. B.P. (sitting) \_\_\_\_/\_\_\_\_ CHECK IF NEGATIVE
- II. Vision: L 20/\_\_\_\_ R 20/\_\_\_\_
- III. Skin \_\_\_\_\_  
Mouth (teeth, tonsils, throat) \_\_\_\_\_  
Eyes: Pupils L \_\_\_\_\_ R \_\_\_\_\_ Feet \_\_\_\_\_
- IV. Orthopedics: \_\_\_\_\_  
Cervical Spine/Back \_\_\_\_\_  
Shoulders \_\_\_\_\_  
Arm/Elbow/Wrist/Hand \_\_\_\_\_  
Knees \_\_\_\_\_  
Ankles \_\_\_\_\_
- V. Chest: \_\_\_\_\_  
PMI \_\_\_\_\_  
Pulses \_\_\_\_\_  
Rhythm \_\_\_\_\_  
Murmur \_\_\_\_\_  
Lungs \_\_\_\_\_
- VI. Lymphatics: \_\_\_\_\_  
Cervical \_\_\_\_\_  
Axillary \_\_\_\_\_  
Abdomen: Organs \_\_\_\_\_  
Genitalia: \_\_\_\_\_  
Maturation Index (Tanner Staging) \_\_\_\_\_

ANY IMMUNIZATIONS IN THE PAST YEAR? (Dates) \_\_\_\_\_

COMMENTS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Private Physician \_\_\_\_\_  
Address \_\_\_\_\_

Date of Exam \_\_\_\_\_  
Phone Number \_\_\_\_\_

---

**DO NOT WRITE BELOW THIS LINE - FOR SCHOOL USE ONLY**

DISPOSITION: PARTICIPATION FULL LIMITED NONE REVIEW

COMMENTS: \_\_\_\_\_

SCHOOL PHYSICIAN: \_\_\_\_\_ DATE: \_\_\_\_\_