Barclay College

607 N. Kingman, Haviland, KS 67059; 620.862.5252

PPE

History

PRE-PARTICIPATION PHYSICAL EVALUATION

Name: _____ Sex: _____ Age: _____ Date of Birth: _____

TO BE COMPLETED ANNUALLY BY EVERY PARTICIPANT

Grade: _____ Sport(s): _____

Address: _____

Phone: ( ) _____ Personal Physician: _____

In case of emergency contact:

Name: _____ Relationship: _____ Phone (H): _____ Phone (W): _____

PPE shall not be taken earlier than May 1 preceding the school year for which it is applicable. Answer the following questions below PRIOR TO EXAMINATION by physician. Explain the "YES" answers in the space below. Circle the number of the questions you do not know.

Yes	No		
☐	☐	1.	**Have you had a medical illness or injury since your last check up of sports physical? Do you have an ongoing or chronic illness?**
☐	☐	2.	**Have you ever been hospitalized overnight? Have you ever had surgery?**
☐	☐	3.	**Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler?**
☐	☐	4.	**Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?**
☐	☐	5.	**Do you have any allergies? (for example, to pollen, medicine, food, or stinging insects)? Have you ever had a rash or hive during or after exercise?**
☐	☐	6.	**Have you ever passed out during or after exercise?**
☐	☐	7.	**Have you ever been dizzy during or after exercise?**
☐	☐	8.	**Have you ever had chest pain during or after exercise?**
☐	☐	9.	**Do you get tired more quickly than others do during exercise?**
☐	☐	10.	**Have you ever had racing of your heart or skipped heartbeats?**
☐	☐	11.	**Have you had high blood pressure or high cholesterol?**
☐	☐	12.	**Have you ever been told you have a heart murmur?**
☐	☐	13.	**Has any family member or relative died of heart problems or sudden death before the age of 50?**
☐	☐	14.	**Have you had a severe viral infection (for example, myocarditis, or mononucleosis) within the last month?**
☐	☐	15.	**Has a physician ever denied or restricted your participation in sports for any heart problems?**
☐	☐	16.	**Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?**
☐	☐	17.	**Have you ever had a head injury or concussion? When? How Many?**
☐	☐	18.	**Have you ever been knocked out, become unconscious, or lost your memory?**
☐	☐	19.	**Have you ever had a seizure?**
☐	☐	20.	**Have you ever had numbness or tingling in your arms, hands, legs, or feet?**
☐	☐	21.	**Have you ever had a stinger, burner, or pinched nerve?**
☐	☐	22.	**Have you ever become ill from exercising in the heat?**
☐	☐	23.	**Do you cough, or weeze, or have trouble breathing during or after activity?**
☐	☐	24.	**Do you have asthma?**
☐	☐	25.	**Do you use an inhaler before exercise?**
☐	☐	26.	**Do you have seasonal allergies requiring medical treatment?**
☐	☐	27.	**Do you use any special protective or corrective equipment or devices that aren't usually used for your sport of position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?**
☐	☐	28.	**Have you had any problems with your eyes or vision?**
☐	☐	29.	**Have you ever had a sprain, strain, fracture or dislocation of a muscle, tendon, bone, or joint?**

If yes check the appropriate spot below.

☐ **Head**	☐ **Elbow**	☐ **Hip**	☐ **Chest**	☐ **Hand**	☐ **Foot**
☐ **Neck**	☐ **Forearm**	☐ **Thigh**	☐ **Shin/Calf**	☐ **Finger**	☐ **Ankle**
☐ **Back**	☐ **Wrist**	☐ **Knee**	☐ **Shoulder**	☐ **Upper Shoulder**	☐ **Upper Arm**

☐ ☐ **30. Do you want to weigh more or less than you do now?**
☐ ☐ **31. Do you lose weight regularly to meet weight requirements for your sport?**
☐ ☐ **32. Has a doctor told you or a family member that you are at risk for blood disorders? Ex: Sickle Cell, etc…**
☐ ☐ **33. Were you born without or are you missing a kidney, testicle, or any other organs?**
☐ ☐ **34. Do you feel that you have fatigue or increased shortness of breath with activity?**
☐ ☐ **35. Do you have any concerns that you would like to discuss with the doctor?**

FEMALES ONLY

☐ ☐ **36. Have you begun menstruation?**
☐ ☐ **37. If yes, are you ever experiencing any problems? (i.e., irregularity, pain, etc.)?**

IDENTIFY "YES" ANSWERS (BY NUMBER) and explain:

_____

_____

PHYSICAL EXAMINATION
PRE-PARTICIPATION PHYSICAL EVALUATION

Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Pulse: _____ Blood Pressure: ____/____

Vision: _____ R 20/_____ L 20/_____ Corrected: Y N Pupils: Equal Unequal_____

Recent immunizations Dates: Td Tdap Hep B Varicella HPV Meningococcal

	NORMAL	ABNORMAL FINDINGS	INITIALS
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia/Hernia			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

CLEARANCE

____CLEARED FOR ALL ACTIVITIES
____NOT CLEARED FOR:
REASON: _____

RECOMMENDATIONS: _____

I HEREBY CERTIFY THAT I AM QUALIFIED BY TRAINING AND EXPERIENCE TO PROPERLY PREFORM THE EXAMINATION AND MAKE THE EVALUATION REFLECTED ON THIS FORM

Name of physician (print/type): _____ Date: _____

Address: _____ Phone: ( ) _____

Signature of physician: _____, MD, DO, DC or RPA *(Please Circle)*