ALABAMA HIGH SCHOOL ATHLETIC ASSOCIATION

Preparticipation Physical Evaluation Form

**History**

<table>
<thead>
<tr>
<th>Name</th>
<th>Sex</th>
<th>Age</th>
<th>Date of birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>School</td>
<td>Grade</td>
<td></td>
<td>Sport</td>
</tr>
</tbody>
</table>

Explain "Yes" answers below:

1. Has a doctor ever restricted/denied your participation in sports?
   - Yes
   - No

2. Have you ever been hospitalized or spent a night in a hospital?
   - Have ever had surgery?
   - Yes
   - No

3. Do you have any ongoing medical conditions (like Diabetes or Asthma)?
4. Are you presently taking any medications or pills (prescription or over-the-counter?)
5. Do you have any allergies (medicine, pollens, foods, bees or other stinging insects)?
6. Have you ever passed out during or after exercise?
   - Have you been dizzy during or after exercise?
   - Yes
   - No

7. Do you have any skin problems (itching, rashes, staph, MRSA, acne)?
8. Have you ever had a headache or concussion?
   - Have you ever been knocked out or unconscious?
   - Yes
   - No

9. Have you ever had a heart condition?
   - Has anyone in your family had heart problems or a sudden death before age 50?
   - Yes
   - No

10. Do you have any other medical problems (infectious mononucleosis, diabetes, infectious diseases, etc.)?
11. Have you had a medical problem or injury since your last evaluation?
12. Have you ever been told you have sickle cell trait?

13. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other
    injuries of any bones or joints?
    - Head
    - Back
    - Shoulder
    - Forearm
    - Hand
    - Hip
    - Knee
    - Ankle
    - Neck
    - Chest
    - Elbow
    - Wrist
    - Finger
    - Thigh
    - Shin
    - Foot

14. When was your first menstrual period?
15. When was your last menstrual period?
16. What was the longest time between your periods last year?

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

Signature of athlete __________________________ Date ________________

Signature of parent/guardian __________________________

DUPLICATE AS NEEDED
Preparticipation Physical Evaluation

Physical Examination

Rule 1, Sec. 14 — In order for a student to be eligible for interscholastic athletics, there must be on file in the Superintendent's or Principal's office a current physician's statement certifying that the student has passed a physical exam, and that in the opinion of the examining physician (M.D. or D.O.) the student is fully able to participate in interscholastic athletics (Grades 7-12). The AHSAA Physicians Certificate (Form 5) must be used. A physical exam will satisfy the requirement for one calendar year from the date of the exam.

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>BP</th>
<th>Pulse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision R 20</td>
<td>L 20</td>
<td>Corrected: Y N</td>
<td></td>
</tr>
</tbody>
</table>

**LIMITED**

<table>
<thead>
<tr>
<th>Cardiovascular</th>
<th>Normal</th>
<th>Abnormal Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lungs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**COMPLETE**

<table>
<thead>
<tr>
<th>Genitalia (males)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Musculoskeletal</td>
<td></td>
</tr>
<tr>
<td>Neck</td>
<td></td>
</tr>
<tr>
<td>Shoulder</td>
<td></td>
</tr>
<tr>
<td>Elbow</td>
<td></td>
</tr>
<tr>
<td>Wrist</td>
<td></td>
</tr>
<tr>
<td>Hand</td>
<td></td>
</tr>
<tr>
<td>Back</td>
<td></td>
</tr>
<tr>
<td>Knee</td>
<td></td>
</tr>
<tr>
<td>Ankle</td>
<td></td>
</tr>
<tr>
<td>Foot</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

Clearance:
A. Cleared
B. Cleared after completing evaluation/rehabilitation for:__________________________________________
C. Not cleared for:  □ Collision  □ Contact
                         □ Noncontact  ____ Strenuous  ____ Moderately strenuous  ____ Nonstrenuous

Due to: ____________________________________________

Recommendation:____________________________________

Name of physician ___________________________________ Date ____________________________
Address ____________________________________________ Phone ____________________________
Signature of physician ________________________________ M.D. or D.O.