

**WARWICK PUBLIC SCHOOLS ATHLETIC PHYSICAL FORM**  
 PREPARTICIPATION EVALUATION-HISTORY Completed by ATHLETE or PARENT

Name \_\_\_\_\_ Date \_\_\_\_\_  
 Address \_\_\_\_\_ School \_\_\_\_\_

- |  |            |           |
|--|------------|-----------|
|  | <b>YES</b> | <b>NO</b> |
| 1. Have any members of your family under age 50 had a heart attack or "heart problems"?                            | _____      | _____     |
| 2. Have you ever been told you have a heart murmur, high blood pressure, extra heartbeats, or a heart abnormality? | _____      | _____     |
| 3. Do you have to stop when running a (1/4 mile) track twice?  | _____      | _____     |
| 4. Are you taking any medications?   | _____      | _____     |
| 5. Have you ever "passed out" or been "knocked out" (concussion)?  | _____      | _____     |
| 6. 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 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 (hayfever, hives, asthma, or medicine)?   | _____      | _____     |

**HEALTH INSURANCE PROVIDER** \_\_\_\_\_  
**NUMBER** \_\_\_\_\_ **SCHOOL INSURANCE** \_\_\_\_\_ **YES** \_\_\_\_\_ **NO** \_\_\_\_\_

**SPORTS MEDICINE PHYSICAL EXAMINATION FORM - Must be completed annually prior to the start of the sport season**

Name \_\_\_\_\_ Age \_\_\_\_\_ Grade: \_\_\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ / \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Vision: OK \_\_\_\_\_ Needs Investigation \_\_\_\_\_

**Medical Examination**

	<b>OK</b>	<b>Problem</b>	<b>Comment</b>
Dental _____			
Eyes/fundus _____			
Ears, Nose, Throat _____			
Head & Neck _____			
Skin & Scalp _____			
Lymphatics _____			
Thorax _____			
Lungs _____			
Heart _____			
Abdomen _____			
Hernia _____			
Genitalia _____			
Neurologic _____			
Neck & Shoulder _____			
Elbow, Hand & Wrist _____			
Back _____			
Knee _____			
Ankle _____			
Feet _____			

**Review by Physician:**  
 \_\_\_\_\_ No Athletic Participation  
 \_\_\_\_\_ Limited Participation, e.g., \_\_\_\_\_  
 \_\_\_\_\_ Clearance Withheld Until: \_\_\_\_\_  
 \_\_\_\_\_ Full Unlimited Participation.

**Advice** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
**Physician's Name (Printed)** \_\_\_\_\_  
**Address** \_\_\_\_\_  
**Physician's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_