Student Health Services
112 College Road
Loch Sheldrake, NY 12759
845-434-5750 ext. 4247
Fax: 845-434-3628

Team:__________________________

# PRE-PARTICIPATION PHYSICAL EVALUATION

Name:________________________________________ Phone:______________________________

Address:_____________________________ City:_____________________ State:________________

Sex:___ Age:_______ Date of Birth:___________ Personal Physician:______________________________

Pervious school attended & dates:__________________________________________________________

| Explain “Yes” answers below: | Yes | No |
|---|---|---|
| 1. Have you ever been hospitalized? | □ | □ |
| Have you ever had surgery? | □ | □ |
| Are you presently under a doctor’s care? | □ | □ |
| 2. Are you presently taking any medications? | □ | □ |
| 3. Do you have any allergies (medicine, bees, etc)? | □ | □ |
| 4. Have you ever passed out during or after exercise? | □ | □ |
| Have you ever been dizzy during or after exercise? | □ | □ |
| Have you ever had chest pain during or after exercise? | □ | □ |
| Have you ever had high blood pressure? | □ | □ |
| Have you ever been told that you have a heart murmur? | □ | □ |
| Have you ever had racing of your heart or skipped heartbeats? | □ | □ |
| Has anyone in your family died of heart problems or a sudden death before age 50? | □ | □ |
| Has anyone in your family had Marfan’s syndrome? | □ | □ |
| 5. Do you have any skin problems (itching, rashes, acne)? | □ | □ |
| 6. Have you ever had a head injury? | □ | □ |
| Have you ever been knocked out or unconscious? | □ | □ |
| Have you ever had a seizure or epilepsy? | □ | □ |
| Have you ever had a stinger, burner or pinched nerve? | □ | □ |
| 7. Have you ever had heat cramps, heat illness or muscle cramps? | □ | □ |
| 8. Do you have trouble breathing or do you cough during or after activity? | □ | □ |
| 9. Do you use any special equipment (pads, braces, neck rolls, eye guards, etc.)? | □ | □ |
| 10. Have you had any problems with your eyes or vision? | □ | □ |
| Do you wear glasses, contacts or protective eye wear? | □ | □ |
| 11. Are you missing an eye, kidney or testicle? | □ | □ |

12. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bone/joints?

| | | | | | | |
|---|---|---|---|---|---|---|
| □ Head | □ Shoulder | □ Thigh | □ Neck | □ Elbow | □ Knee | □ Foot |
| □ Forearm | □ Shin/Calf | □ Back | □ Wrist | □ Ankle | □ Hip | □ Hand |

| | Yes | No |
|---|---|---|
| 13. Have you had any other medical problems (infectious mononucleosis, diabetes, anemia, etc)? | □ | □ |
| 14. Have you had a medical problem or injury since your last evaluation? | □ | □ |
| 15. When was your last tetanus shot? | □ | □ |
| 16. When was your first & last menstrual period? | □ | □ |
| What was the longest time between your periods last year? | □ | □ |

Explain “YES” answers below:

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

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

Date:____________________ Signature of athlete:___________________________________________

Revised 4/4/18