



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?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had surgery?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you presently under a doctor's care?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you presently taking any medications?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have any allergies (medicine, bees, etc)?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever passed out during or after exercise?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been dizzy during or after exercise?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had chest pain during or after exercise?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had high blood pressure?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been told that you have a heart murmur?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had racing of your heart or skipped heartbeats?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Has anyone in your family died of heart problems or a sudden death before age 50?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Has anyone in your family had Marfan's syndrome?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any skin problems (itching, rashes, acne)?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever had a head injury?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been knocked out or unconscious?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a seizure or epilepsy?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a stinger, burner or pinched nerve?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had heat cramps, heat illness or muscle cramps?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have trouble breathing or do you cough during or after activity?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you use any special equipment (pads, braces, neck rolls, eye guards, etc.)?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you had any problems with your eyes or vision?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you wear glasses, contacts or protective eye wear?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Are you missing an eye, kidney or testicle?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bone/joints?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Head <input type="checkbox"/> Shoulder <input type="checkbox"/> Thigh <input type="checkbox"/> Neck <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Foot    |                          |                          |
| <input type="checkbox"/> Forearm <input type="checkbox"/> Shin/Calf <input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Ankle <input type="checkbox"/> Hip <input type="checkbox"/> Hand |                          |                          |
| 13. Have you had any other medical problems (infectious mononucleosis, diabetes, anemia, etc)?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you had a medical problem or injury since your last evaluation?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. When was your last tetanus shot?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. When was your first & last menstrual period?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| What was the longest time between your periods last year?.....   | <input type="checkbox"/> | <input type="checkbox"/> |

Explain "YES" answers below:

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

Date: \_\_\_\_\_ Signature of athlete: \_\_\_\_\_