### Preparticipation Physical Evaluation

**THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM**

- **Date of Exam**
- **Name**
- **Date of birth**
- **Sex**
- **Age**
- **Grade**
- **School**
- **Sport(s)**

1. Type of disability
2. Date of disability
3. Classification (if available)
4. Cause of disability (birth, disease, accident/trauma, other)
5. List the sports you are interested in playing

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you regularly use a brace, assistive device, or prosthetic?</td>
<td></td>
<td></td>
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<tr>
<td>Do you use any special brace or assistive device for sports?</td>
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<tr>
<td>Do you have any rashes, pressure sores, or any other skin problems?</td>
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<tr>
<td>Do you have a hearing loss? Do you use a hearing aid?</td>
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<tr>
<td>Do you have a visual impairment?</td>
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<tr>
<td>Do you use any special devices for bowel or bladder function?</td>
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<tr>
<td>Have you had autonomic dysreflexia?</td>
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<tr>
<td>Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?</td>
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<tr>
<td>Do you have muscle spasticity?</td>
<td></td>
<td></td>
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<tr>
<td>Do you have frequent seizures that cannot be controlled by medication?</td>
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</tbody>
</table>

Explain “yes” answers here

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Please indicate if you have ever had any of the following.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atlantoaxial instability</td>
<td></td>
<td></td>
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<tr>
<td>X-ray evaluation for atlantoaxial instability</td>
<td></td>
<td></td>
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<tr>
<td>Dislocated joints (more than one)</td>
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<td></td>
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<tr>
<td>Easy bleeding</td>
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<td></td>
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<tr>
<td>Enlarged spleen</td>
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<td></td>
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<tr>
<td>Hepatitis</td>
<td></td>
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<tr>
<td>Osteopenia or osteoporosis</td>
<td></td>
<td></td>
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<tr>
<td>Difficulty controlling bowel</td>
<td></td>
<td></td>
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<tr>
<td>Difficulty controlling bladder</td>
<td></td>
<td></td>
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<tr>
<td>Numbness or tingling in arms or hands</td>
<td></td>
<td></td>
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<tr>
<td>Numbness or tingling in legs or feet</td>
<td></td>
<td></td>
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<tr>
<td>Weakness in arms or hands</td>
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<td></td>
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<tr>
<td>Weakness in legs or feet</td>
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<td></td>
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<tr>
<td>Recent change in coordination</td>
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<tr>
<td>Recent change in ability to walk</td>
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<tr>
<td>Spina bifida</td>
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<td></td>
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<tr>
<td>Latex allergy</td>
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</tbody>
</table>

Explain “yes” answers here

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

Signature of athlete ___________ Signature of parent/guardian ___________ Date ___________
Preparticipation Physical Evaluation

Physician Reminders
1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

Examination

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
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<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

BP / ( / ) Pulse

<table>
<thead>
<tr>
<th>Vision R 20/</th>
<th>L 20/</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrected</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Medical</th>
<th>Normal</th>
<th>Abnormal Findings</th>
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</thead>
</table>

- Appearance
  - Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)

- Eyes/ears/nose/throat
  - Pupils equal
  - Hearing

- Lymph nodes

- Heart
  - Murmurs (auscultation standing, supine, +/- Valsalva)
  - Location of point of maximal impulse (PMI)

- Pulses
  - Simultaneous femoral and radial pulses

- Lungs

- Abdomen

- Genitourinary (males only)

- Skin
  - HSV, lesions suggestive of MRSA, linea corporis

- Neurologic

Musculoskeletal

- Neck
- Back
- Shoulder/arm
- Elbow/forearm
- Wrist/hand/fingers
- Hip/thigh
- Knee
- Leg/ankle
- Foot/toes

- Functional
  - Duck-walk, single leg hop

Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

Consider (6) exam if in private setting. Having third party present is recommended.

Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

Clear for all sports without restriction
Clear for all sports without restriction with recommendations for further evaluation or treatment for

Not cleared
- Pending further evaluation
- For any sports
- For certain sports

Reason

Recommendations

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type): ____________________________ Date: ____________
Address: ____________________________ Phone: ________________
Signature of physician: ____________________________

Preparticipation Physical Evaluation

CLEARANCE FORM

Name ___________________________ Sex □ M □ F Age ______________ Date of birth ________________

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for __________________________

☐ Not cleared

☐ Pending further evaluation

☐ For any sports

☐ For certain sports

Reason __________________________

Recommendations __________________________

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Name of physician (print/type) _______________________________________________________________ Date ________________

Address ___________________________________________ Phone __________________________

Signature of physician _______________________________________________________________ MD or DO

EMERGENCY INFORMATION

Allergies __________________________________________

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