ALABAMA HIGH SCHOOL ATHLETIC ASSOCIATION

Preparticipation Physical Evaluation Form

Revised 2018

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History

Name______________________________ Sex________ Age______ Date__________________

Address____ Date of birth__________________

School____ Phone__________________

Grade__________ Sport__________________

Explain "Yes" answers below:

		Yes	No
1.	Has a doctor ever restricted/denied your participation in sports?	☐	☐
2.	Have you ever been hospitalized or spent a night in a hospital?	☐	☐
	Have ever had surgery?	☐	☐
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 ever been dizzy during or after exercise?	☐	☐
	Have you ever had chest pain or discomfort in your chest during or after exercise?	☐	☐
	Do you tire more quickly than your friends during exercise?	☐	☐
	Have you ever had high blood pressure?	☐	☐
	Have you ever been told that you have a heart murmur, high cholesterol, or heart infection?	☐	☐
	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?	☐	☐
	Does anyone in your family have a heart condition?	☐	☐
	Has a doctor ever ordered a test on your heart (EKG, echocardiogram)?	☐	☐
7.	Do you have any skin problems (itching, rashes, staph, MRSA, acne)?	☐	☐
8.	Have you ever had a head injury or concussion?	☐	☐
	Have you ever been knocked out or unconscious?	☐	☐
	Have you ever had a seizure?	☐	☐
	Have you ever had a stinger, burner, pinched nerve, or loss of feeling or weakness in your arms or legs?	☐	☐
9.	Have you ever had heat or muscle cramps?	☐	☐
	Have you ever been dizzy or passed out in the heat?	☐	☐
10.	Do you have trouble breathing or do you cough during or after activity?	☐	☐
	Do you take any medications for asthma (for instance, inhalers)?	☐	☐
11.	Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)?	☐	☐
12.	Have you had any problems with your eyes or vision?	☐	☐
	Do you wear glasses or contacts or protective eye wear?	☐	☐
13.	Have you had any other medical problems (infectious mononucleosis, diabetes, infectious diseases, etc.)?	☐	☐
14.	Have you had a medical problem or injury since your last evaluation?	☐	☐
15.	Have you ever been told you have sickle cell trait?	☐	☐
	Has anyone in your family had sickle cell disease or sickle cell trait?	☐	☐
16.	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	☐	☐
17.	When was your first menstrual period?______________________ When was your last menstrual period?______________________ What was the longest time between your periods last year?______________________		

Explain "Yes" answers:

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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

FORM 5

Rev. 2018 *(The revised 2018 form is the official form accepted by the AHSAA.)*