Union Athletic Training Center
2024-2025 Preparticipation Physical Examination

PARENTS: keep the original for your records, provide a COPY to your coach or email to newman.dan@unionps.org

Date of exam: _____

Last Name _____ **First Name** _____ **Age** _____ **Date of Birth** _____

Grade (2024-2025) _____ **Union Student ID#** _____ **Sex** _____ **Sport/Activity** _____

Personal Physician _____ **Phone** _____

List any past and current medical conditions (asthma, diabetes, anemia, etc.)**:** _____

Have you ever had surgery? If yes, list all past surgical procedures: _____

Medicines and supplements: List all current prescriptions, over-the-counter medicines and supplements (herbal and nutritional). _____

Do you have any allergies? If yes, please list all (pollens, food, medicines, stinging insects): _____

Patient Health Questionnaire Version 4 (PHQ-4) Over the last two weeks, how often have you been bothered by any of the following (circle response):

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3

(A sum of ≥ 3 is considered positive on either subscale [questions 1 & 2, or questions 3 & 4] for screening purposes)

	GENERAL QUESTIONS Explain "Yes" answers at the end of this form. Circle questions if you do not know the answer.	YES	NO
1	Do you have concerns that you would like to discuss with your provider?		
2	Has a provider ever denied or restricted your particiation in sports for any reason?		
3	Do you have any ongoing medical issues or recent illness?		
	HEART HEALTH QUESTIONS ABOUT YOU	**YES**	**NO**
4	Have you ever passed out or nearly passed out during or after exercise?		
5	Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6	Does your heart ever race, flutter in your chest or skip beats (irregular beats) during exercise?		
7	Has a doctor every told you that you have any heat problems?		
8	Has a cdoctor ever requested a test for your heart? For example, electrocariography (ECG) or echocardiography?		
9	Do you get light-headed or feel more short of breath than your friends during exercise?		
10	Have you ever had a seizure?		
	HEART QUESTIONS ABOUT YOUR FAMILY	**UNSURE**	**YES**	**NO**
11	Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 (including drowning, unexplained car accident, or sudden infant death syndrome)?			
12	Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT Syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?			
13	Has anyone in your family had a pacemaker or an implanted device before age 35?			

	BONE AND JOINT QUESTIONS	YES	NO
14	Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint or tendon that caused you to miss a practice or game?		
15	Do you have a bone, muscle, ligament or joint injury that bothers you?		
	MEDICAL QUESTIONS	**YES**	**NO**
16	Do you cough, wheeze or have difficulty breathing during or after exercise?		
17	Are you missing a kidney, eye, a testicle, your spleen or any other organ?		
18	Do you have groin, testicle pain or a painful bulge or hernia in the groin area?		
19	Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphlococcus aureus (MRSA)?		
20	Have you had a concussion or a head injury that caused confusion, a prolonged headache or memory problems?		
21	Have you ever had numbness, tingling or weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22	Have you ever become ill while exercising in the heat?		
23	Do you or someone in your family have sickle cell trait or disease? **UNSURE**		
24	Have you ever had or do you have any promlems with your eyes or vision?		
25	Do you worry about your weight?		
26	Are you trying to or has someone recommended that you gain or lose weight?		
27	Are you on a special diet or do you avoid certain types of foods or food groups		
28	Have you ever had an eating disorder?		
	MENSTRUAL QUESTIONS **N/A**	**YES**	**NO**
29	Have you ever had a menstrual period?		
30	How old were you when you had your first menstrual period?		
31	When was your most recent menstrual period?		
32	How many periods have you had in the past 12 months?		

Please explain "YES" answers here: _____

If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a results of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given to said student by any physician, athletic trainer, nurse or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student.

I (we) hereby state, to the best of my (our) knowledge, my (our) answers to above questions are complete and correct.

Parent/Guardian Signature _____ **Date** _____

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2024-2025 Preparticipation Physical Examination Page 2

PARENTS: keep the original for your records, provide a COPY to your coach or email to newman.dan@unionps.org

Last Name _____ **First Name** _____

Age _____ **Date of Birth** _____ **Grade (2024-2025)** _____ **Union Student ID#** _____ **Sex** _____

PHYSICAL EXAMINATION

Height: Weight: BP: / Pulse: Vision: R 20/ L20/ Corrected: Y N

MEDICAL	NORMAL	ABMORNAL FINDINGS
Appearance ⊗ Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse (MVP), and aortic insufficiency)		
Eyes, ears nose and throat ⊗ Pupils equal ⊗ Hearing		
Lymph nodes		
Heart ⊗ Murmurs (auscultation standing, auscultation supine, and +/- Valsalva maneuver)		
Lungs		
Abdomen		
Skin ⊗ Herpes simplex virus (HSV), leisions of methicillin-resistant Staphyloccus aureus (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABMORNAL FINDINGS**
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional ⊗ Double-leg squat test, single leg squat test and box drop or step drop test		

____ Medically eligible for all sports without restriction

____ Medically eligible for all sports with recommendations for further evaluation or treatment of: _____

____ Medically eligible for certain sports: _____

____ Not medically eligible pending further evaluation for: _____

____ Not medically eligible for any sports

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 participation the sport(s)as outlined above.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 health care provider (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care provider: _____