



Archdiocese of Miami
 Department of Schools
Athletic Pre-participation Physical Evaluation (Page 1 of 2)
 This completed form must be kept on file by the school

1. Student Information (to be completed by the parent).

Student Name: _____ Sex: _____ Age: _____ Date of Birth: ____/____/____
 School: _____ Grade in School: _____ Sport(s) expected to play: _____
 Home Address: _____ Home Phone () _____
 Name of Parent/Guardian: _____
 Person to Contact in Case of Emergency: _____
 Relationship to Student: _____ Home Phone: () _____ Work Phone: () _____
 Personal/Family Physician: _____ City/State: _____ Office Phone: () _____

Part 2. Medical History (to be completed by parent). Explain "yes" answers below. Circle questions for which you do not know the answer

	Yes	No		Yes	No
Has child had a medical illness or injury since the last check up or sports physical?	_____	_____	25. Has child ever become ill from exercising in the heat?	_____	_____
Does child have an ongoing chronic illness?	_____	_____	27. Does child cough, wheeze or have trouble breathing during or after activity?	_____	_____
Has child ever been hospitalized overnight?	_____	_____	28. Does child have asthma?	_____	_____
Has child ever had surgery?	_____	_____	29. Does child have seasonal allergies that require medical treatment?	_____	_____
Is child currently taking any prescription or nonprescription (over the counter) medications or pill or using an inhaler?	_____	_____	30. Does child have any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	_____	_____
Has child ever taken any supplements or vitamins to help gain or lose weight or improve performance?	_____	_____	31. Has child had any problems with his/her eyes or vision?	_____	_____
Does child have any allergies (for example to pollen, medicine, food or stinging insects)?	_____	_____	32. Does child wear glasses, contacts, or protective eye wear?	_____	_____
Has child ever had rash or hives develop during or after exercise?	_____	_____	33. Has child ever had a sprain, strain, or swelling after injury?	_____	_____
Has child ever passed out during or after exercise?	_____	_____	34. Has child broken or fractured any bones or dislocated any joints?	_____	_____
Has child ever been dizzy during or after exercise?	_____	_____	35. Has child had any other problems with pain or swelling in muscles, tendons, bones, or joints?	_____	_____
Has child ever had chest pain during or after exercise?	_____	_____	<i>If yes, check appropriate blank and explain below:</i>		
Does child get tired more quickly than friends during exercise?	_____	_____	___ Head	___ Elbow	___ Hip
Has child ever had racing of the heart or skipped heartbeats?	_____	_____	___ Neck	___ Forearm	___ Thigh
Has child had high blood pressure or high cholesterol?	_____	_____	___ Back	___ Wrist	___ Knee
Has child ever been told he/she has a heart murmur?	_____	_____	___ Chest	___ Hand	___ Shin/Calf
Has any family member or relative died of heart problems or sudden death before age 50?	_____	_____	___ Shoulder	___ Finger	___ Ankle
Has child had severe viral infection (for example, myocarditis or mononucleosis) within the last month?	_____	_____	___ Upper Arm	___ Foot	
Has a physician ever denied or restricted child's participation in sports for any heart problems?	_____	_____	36. Does child want to weigh more or less than child weighs now?	_____	_____
Does child have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	_____	_____	37. Does child lose weight regularly to meet weight requirements for a sport?	_____	_____
Has child ever had a head injury or concussion?	_____	_____	38. Does child feel stressed out?	_____	_____
Has child ever been knocked out, become unconscious, or lost his/her memory?	_____	_____	39. Record the dates of his/most recent immunizations (shots) for:		
Has child ever had a seizure?	_____	_____	Tetanus _____ Measles: _____		
Does child have frequent or severe headaches?	_____	_____	Hepatitis B _____ Chickenpox _____		
Has child ever had numbness or tingling in his/her arms, hands, legs, or feet?	_____	_____			
Has child ever had a stinger, burner, or pinched nerve?	_____	_____			

Explain "Yes" answers here: _____

I hereby state, to the best of my knowledge, that my answers to the above questions are complete and correct.
 Signature of Parent/Guardian: _____ Date: _____