



O.K. Conference  
Pre-Participation Physical Exam Form

Medical Examination

THIS SIDE TO BE COMPLETED BY EXAMINING MEDICAL PROFESSIONAL

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ HR: \_\_\_\_\_ BP: \_\_\_\_\_ BP reek: \_\_\_\_\_  
Corrective Lenses: Y or N Vision: R \_\_\_\_\_ L \_\_\_\_\_

Physical Exam	Normal	Abnormal
General Appearance		
HEENT		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Skin		
Neurologic		
Spine		
Upper Extremity		
Lower Extremity		
Joint Specific (optional)		
Hernia (males only)		

COMMENTS

General Medical	Musculoskeletal

**RECOMMENDATIONS:**

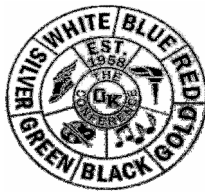
- CLEARED WITHOUT RESTRICTIONS
- Cleared for LIMITED PARTICIPATION (specify) \_\_\_\_\_
- NOT CLEARED for participation (explanation) \_\_\_\_\_
- Requires further evaluation before final recommendation \_\_\_\_\_

I certify that I have examined the above student and recommend him/her as being able to compete in supervised athletic activity as dictated by the clearance recommendations above.

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ MD, DO, PA, or NP

A Current-Year Physical is one given on or after April 15 of the previous school year.



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Emergency Information

School: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: M F Grade: \_\_\_\_\_

Parent/Legal Guardian Name(s): \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Phone #: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Emergency Contact(s):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Information:

Family Insurance Co.: \_\_\_\_\_ Phone: \_\_\_\_\_

Contract/Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

Parent/Legal Guardian Consent & Assumption of Risk:

Participation in interscholastic athletics requires an acceptance of risk of injury. These risks include, but are not limited to the following: death, quadriplegia, paraplegia, internal injury, closed head injury (possibly including post-concussion syndrome) and musculo-skeletal injuries (including sprains, strains, and fractures). Some of these injuries may result in medical treatment, surgery, and/or permanent disability. I understand that coaches, athletic trainers, and physicians (including side-line team physicians) will use their professional judgment when administering proper medical treatment. I have had the opportunity to ask questions, hereby recognize the risk of injury, and give my consent for my son/daughter to participate in interscholastic athletics. I further consent for the disclosure of information otherwise protected by FERPA and HIPPA for the purpose of determining eligibility for interscholastic athletics to the MHSAA, OK Conference, and school district. I also agree to accept and comply with all MHSAA, OK Conference, and school district athletic policies.

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Student-Athlete Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Authorization of Treatment:

I, \_\_\_\_\_, hereby give my permission for my son/daughter, \_\_\_\_\_, to undergo medical treatment for any injury or illness he/she may sustain or acquire while participating in interscholastic athletics. I understand that medical personnel, including athletic trainers and sideline team physicians, will perform only those procedures within their training, credentialing, and scope of professional practice to prevent, care for, and rehabilitate athletic injuries or illnesses. In the event more serious medical treatment/procedures are required and I cannot be reached for my consent, I authorize any licensed medical practitioner to perform such treatments/procedures medically necessary to alleviate the problem.

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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### Medical History

1. Do you have any chronic or ongoing medical conditions? Yes No  
If yes, explain: \_\_\_\_\_
2. Have you ever been hospitalized and/or had surgery for any reason? Yes No  
If yes, explain: \_\_\_\_\_
3. Do you have any allergies (medications, insects, foods, etc.)? Yes No  
If yes, explain: \_\_\_\_\_
4. Are you currently taking any medications or supplements (include over-the-counter)? Yes No  
If yes, explain: \_\_\_\_\_
5. Have you had a medical problem or injury since your last physical exam? Yes No  
If yes, explain: \_\_\_\_\_
6. Have you ever passed out or nearly passed out during or after exercise? Yes No  
Have you ever had chest pain, tightness, or pressure during or after exercise? Yes No  
Have you ever been dizzy or light headed during or after exercise? Yes No  
Do you get more tired or short of breath than others during exercise? Yes No  
Does your heart ever race or skip beats (irregular beats) during exercise? Yes No  
Has a doctor ever ordered a test for your heart (e.g. ECG/EKG, echocardiogram)? Yes No  
Have you ever been told you have any of the following (check all that apply):  
 High blood pressure     Heart murmur     High cholesterol  
 A heart infection     Kawasaki disease     Other: \_\_\_\_\_  
Explain ALL yes answers & checked items: \_\_\_\_\_
7. Has anyone in your family died suddenly **or** of heart problems before age 50? Yes No  
Do anyone in your family have a heart problem, pacemaker, or implanted defibrillator? Yes No  
Has anyone in your family had unexplained fainting, seizures, or near drowning? Yes No  
Does anyone in your family have any of the following cardiovascular conditions:  
 Hypertrophic cardiomyopathy     Marfan syndrome     Brugada syndrome  
 Arrhythmogenic right ventricular cardiomyopathy     Long QT syndrome  
 Catecholaminergic polymorphic ventricular tachycardia     Short QT syndrome  
Explain ALL yes answers & checked items: \_\_\_\_\_
8. Have you ever had a concussion, head injury, or recurrent headaches? Yes No  
If yes, explain: \_\_\_\_\_
- Have you ever been knocked out or unconscious? Yes No  
If yes, explain: \_\_\_\_\_
- Do you have headaches with exercise? Yes No  
If yes, explain: \_\_\_\_\_
- Have you ever had any of the following after a hit, blow to the head, or falling:  
 Confusion     Prolonged headache     Inability to move your arms or legs  
 Memory problems     Numbness, tingling, or weakness in your arms or legs  
Explain ALL checked items (include dates): \_\_\_\_\_
- Have you ever had a stinger, burner, or pinched nerve? Yes No  
If yes, explain: \_\_\_\_\_
- Have you ever had seizures, convulsions, or a history of epilepsy? Yes No  
If yes, explain: \_\_\_\_\_

9. Have you ever become ill, dizzy, or passed out while exercising in the heat? Yes No  
If yes, explain: \_\_\_\_\_
- Do you get frequent muscle or heat cramps when exercising? Yes No  
If yes, explain: \_\_\_\_\_
- Do you or someone in your family have sickle cell trait or disease? Yes No  
If yes, explain: \_\_\_\_\_
10. Do you or someone in your family have asthma or another obstructive lung disorder? Yes No  
If yes, explain: \_\_\_\_\_
- Do you cough, wheeze, or have difficulty breathing during or after exercise? Yes No  
If yes, explain: \_\_\_\_\_
- Have you ever used an inhaler or taken asthma medication? Yes No  
If yes, explain: \_\_\_\_\_
11. Do you currently have, or have you EVER HAD any of the following:  
 Hernia     Mononucleosis     Diabetes     Kidney disease     Scoliosis     Absent spleen  
Explain ALL checked items (include dates): \_\_\_\_\_
12. Are you missing one of a set of paired organs (kidneys, eyes, ovaries, testes, etc.)? Yes No  
If yes, explain: \_\_\_\_\_
13. Have you ever sprained, strained, dislocated, fractured, broken, experienced repeated swelling in, had a stress fracture in, or otherwise injured any bones or joints? (check all that apply)  
 Head     Neck     Chest/ribs     Back     Shoulder     Forearm     Elbow     Wrist  
 Hip     Thigh     Calf/shin     Knee     Ankle     Foot/toes     Hand/fingers  
Explain ALL checked answers (include dates): \_\_\_\_\_
14. Have you ever had a condition/injury that required x-rays, MRI, CT scan, or therapy? Yes No  
If yes, explain: \_\_\_\_\_
15. Do you use any special equipment (braces, pads, mouthguards, neck rolls, etc.)? Yes No  
If yes, explain: \_\_\_\_\_
16. Have you had any problems with your vision or injuries to your eyes? Yes No  
Do you wear glasses, corrective lenses, or protective eyewear? Yes No  
Explain ALL yes answers: \_\_\_\_\_
17. Have you ever had any skin problems (rashes, itching, MRSA, herpes, acne)? Yes No  
If yes, explain: \_\_\_\_\_
18. Have you ever had an eating disorder or restricted food to lose weight? Yes No  
Do you want to weigh MORE or LESS than you do now? Yes No  
Do you feel stressed? Yes No  
Explain ALL yes answers: \_\_\_\_\_
20. **FEMALES ONLY** Age at 1st menstrual period? \_\_\_\_\_ Date of most recent? \_\_\_\_\_  
Number of periods in the last 12 months? \_\_\_\_\_ Longest time between periods? \_\_\_\_\_
21. Has a doctor ever denied or restricted your participation in sports for any reason? Yes No  
If yes, explain: \_\_\_\_\_
- \*\*I hereby state that, to the best of my knowledge, the answers to the above questions are complete and correct.**
- Signature of Athlete: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_