TO: School Administrators

FROM: AAA Office

RE: Physical Exam Forms

The Executive Committee of the Arkansas Activities Association is **recommending** the use of the enclosed physical exam forms.

Form A and Form B are recommended to be used for students the first time they participate in Junior High and again the first time they participate in Senior High.

Form C may be used in intervening years. These physical exams will be in effect for one calendar year except for those students experiencing physical problems during that year and may need to be re-evaluated.

Form A is a medical history form and requires parental involvement and a parent's signature. Forms B and C shall be signed by the person administering the physical and a parent if applicable.

We hope that these forms will help alleviate concerns expressed by schools and physicians related to the physical health of athletes and spirit group participants.

FORM A

Preparticipation Physical Evaluation

HISTORY Date_____

Name_____Sex_____ Age_____ Date of birth_____

Grade_____ Sport_____

Personal physician_____ _____ _____

Physician's Address Physician's Phone

Explain "Yes" answers below:

1. Have you ever been hospitalized? ..... _____Yes _____No
2. Are you presently taking any medications or pills? ..... _____Yes _____No
3. Do you have any allergies (medicine, bees or other stinging insects)? ..... _____Yes _____No
4. Have you ever passed out during or after exercise? ..... _____Yes _____No
5. Have you ever been dizzy during or after exercise? ..... _____Yes _____No
6. Have you ever had chest pain during or after exercise? ..... _____Yes _____No
7. Do you tire more quickly than your friends during exercise? ..... _____Yes _____No
8. Have you ever had high blood pressure? ..... _____Yes _____No
9. Have you ever been told that you have a heart murmur? ..... _____Yes _____No
10. Have you ever had racing of your heart of skipped heartbeats? ..... _____Yes _____No
11. Has anyone in your family died of heart problems or a sudden death before age 50? . _____Yes _____No
12. Do you have any skin problems (itching, rashes, acne)? ..... _____Yes _____No
13. Have you ever had a head injury? ..... _____Yes _____No
14. Have you ever been knocked out or unconscious? ..... _____Yes _____No
15. Have you ever had a seizure? ..... _____Yes _____No
16. Have you ever had a stinger, burner or pinched nerve? ..... _____Yes _____No
17. Have you ever had heat or muscle cramps? ..... _____Yes _____No
18. Have you ever been dizzy or passed out in the heat? ..... _____Yes _____No
19. Do you have trouble breathing or do you cough during or after activity? ..... _____Yes _____No
20. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc)? ..... _____Yes _____No
21. Have you had any problems with your eyes or vision? ..... _____Yes _____No
22. Do you wear glasses or contacts or protective eye wear? ..... _____Yes _____No
23. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints? ..... _____Yes _____No

_____Head _____Shoulder _____Thigh _____Neck _____Elbow _____Knee _____Chest _____Forearm

_____Shin/Calf _____Back _____Wrist _____Ankle _____Hip _____Hand _____Foot

24. Have you had any other medical problems (infectious mononucleosis, diabetes, etc.)? _____Yes _____No
25. Have you had a medical problem or injury since your last evaluation? ..... _____Yes _____No
26. When was your last tetanus shot? ..... _____
27. When was your last measles immunization? ..... _____
28. When was your first menstrual period? ..... _____
29. When was your last menstrual period? ..... _____
30. When was the longest time between your periods last year? ..... _____

Explain "Yes" answers:

_____

_____

_____

_____

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

Date _____

Signature of athlete _____ Signature of parent/guardian _____

FORM B

Preparticipation Physical Evaluation *(continued)*

Physical Examination Date _____

Name _____ Age _____ Date of birth _____

Height _____ Weight _____ BP _____ / _____ Pulse _____
Vision (R) 20/ _____ (L) 20/ _____ Corrected Y N Pupils _____

		Normal	Abnormal Findings	Initial
LIMITED	Cardiopulmonary			
	Pulses			
	Heart			
	Lungs			
	Tanner Stage	1 2 3 4 5		
COMPLETE	Skin			
	Abdominal			
	Genitalia			
	Musculoskeletal			
	Neck			
	Shoulder			
	Elbow			
	Wrist			
	Hand			
	Back			
	Knee			
	Ankle			
	Foot			
	Other			

Clearance: A. Cleared
B. Cleared After completing evaluation/rehabilitation for _____
C. Not cleared for: _____Collision _____Contact
_____Noncontact _____Strenuous _____Moderately strenuous _____Nonstrenuous

Due to: _____

Recommendation: _____

_____

Name of Physician/Medical Personnel _____ Date _____
Address _____ Phone _____

Signature of Physician/Medical Personnel _____

FORM C

Arkansas Activities Association Physical Exam Form

Master Problem List | Date Identified | Date Resolved

1. _____

2. _____

3. _____

4. _____

Date Entrance Physical Examination _____

PAST MEDICAL HISTORY: Since your initial preparticipation physical examination have you had any of the following? (If yes, please explain what, where and when)

	Yes	No	Explanation
1. Presently taking medication (including birth control pills)?	_____		_____
2. Allergic to medicine, food, bee-sting?	_____		_____
3. Wearing any new appliances - glasses, contact lenses, dentures or hearing aids?	_____		_____
4. History of braces, chipped teeth, bridges?	_____		_____
5. New medical problem requiring treatment or medication?	_____		_____
6. Surgical operations or accidents requiring medical help?	_____		_____
7. Injuries directly related to sports participation? (If so, explain nature of injury)	_____		_____
8. Recent fainting or dizziness while exercising?	_____		_____
9. Recent head injury of loss of consciousness?	_____		_____
10.(For women) Date of last menstrual period?	_____		

REVIEW OF SYSTEMS: Please check if you have developed any new problem to the following areas of your body since your last physical exam.

_____Skin _____Neck _____Head _____Lungs _____Knees _____Eyes _____Heart

_____Mouth/Throat _____Abdomen _____Hips, Legs, Feet _____Blood _____Urination, bowel

_____Shoulders, arms, hands _____Genital (including menstrual for females)

_____Nutrition, weight control _____Muscle strength, feeling _____Mental, emotional

I would like to meet with the team physician _____Yes _____No

I certify that the above information is correct to the best of my knowledge.

Student/Parent Signature _____

VITAL SIGNS:

Height _____ Weight _____

Vision Screening (optional) (R) 20/_____ (L) 20/_____ w/o Glasses

(R) 20/_____ (L) 20/_____ with Glasses

Blood Pressure _____ Pulse _____

Other Testing:

REVIEW BY MEDICAL STAFF:

Approved for participation _____ Other disposition _____

Must see physician _____

Medical Personnel Signature _____ Date _____