PSAL Pre-Participation Physical Exam

Please Note: An additional page has been added to the form entitled “PSAL Health History COVID Addendum.”

Please take all four pages of the form to your medical provider.

The only page that gets returned to the Athletic Director is titled “Recommendations for Participation in Physical Education and Sport.”

HISTORY FORM | Preparticipation Physical Evaluation

(Note: This form is to be filled out by the patient and parent prior to seeing the medical provider. The medical provider should keep this form in the student's medical file. This form does not get returned to the athletic department.)

Date of Exam				Date of Birth	OSIS#
Last Name		First Name			Sport(s)
Sex	Age	Grade	School	School Campus	

Medicines and Allergies

Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking.

Do you carry an inhaler? ❑ **Yes** ❑ **No**

Do you have any allergies? ❑ **Yes** ❑ **No** If yes, please identify specific allergy below:

❑ Medicines _____ ❑ Pollens ❑ Food _____ ❑ Stinging Insects ❑ Latex

Do you carry an Epi Pen? ❑ **Yes** ❑ **No**

Explain "Yes" answers below. Circle questions you don't know the answers to

GENERAL QUESTIONS		Yes	No
1.	Has a doctor ever denied or restricted your participation in sports for any reason?		
2.	Do you have any ongoing medical conditions? If so, please identify below: ❑ Asthma ❑ Anemia ❑ Diabetes ❑ Infections ❑ sickle cell disease or trait Other: _____		
3.	Have you ever been admitted to the hospital?		
4.	Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU		**Yes**	**No**
5.	Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6.	Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7.	Does your heart ever race or skip beats while resting or during exercise?		
8.	Has a doctor ever told you that you have any heart problems? If so, check all that apply: ❑ High blood pressure ❑ A heart murmur ❑ High cholesterol ❑ A heart infection ❑ Kawasaki disease Other: _____		
9.	Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10.	Do you get lightheaded or feel more short of breath than expected during exercise?		
11.	Do you get more tired or short of breath more quickly than your friends during exercise?		
12.	Have you ever had any heart surgery?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		**Yes**	**No**
13.	Does anyone in your family have an irregular heartbeat?		
14.	Has any family member of relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
15.	Does anyone in your family have a heart problem, pacemaker, or defibrillator?		
16.	Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
17.	Do you or someone in your family have sickle cell trait or disease?		
BONE AND JOINT QUESTIONS		**Yes**	**No**
18.	Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
19.	Have you ever had any broken or fractured bones or dislocated joints?		
20.	Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
21.	Have you ever had a stress fracture?		
22.	Have you ever been told that you have or have you had an x-ray for neck instability? (Down syndrome or dwarfism)		
23.	Do you regularly use a brace, orthotics, or other device?		
24.	Do you have a bone, muscle, or joint injury that bothers you?		

MEDICAL QUESTIONS		Yes	No
25.	Do you have any history of juvenile arthritis or connective tissue disease?		
26.	Do any of your joints become painful, swollen, warm, or look red?		
27.	Do you cough, wheeze, or have difficulty breathing during or after exercise?		
28.	Have you ever used an inhaler or taken asthma medicine?		
29.	Is there anyone in your family who has asthma?		
30.	Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
31.	Do you have groin pain or a painful bulge or hernia in the groin area?		
32.	Have you had infectious mononucleosis (mono) within the last month?		
33.	Do you have any rashes, pressure sores, or other skin problems?		
34.	Have you had a herpes or MRSA skin infection?		
35.	Have you ever had a head injury or concussion?		
36.	Have you ever had an unexplained seizure?		
37.	Have you ever had a hit or blow to the head that caused confusion, long-lasting headache, or memory problems?		
38.	Do you have a history of seizure disorder?		
39.	Do you have headaches with exercise?		
40.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
41.	Have you ever been unable to move your arms or legs after being hit or falling?		
42.	Have you ever become ill while exercising in the heat?		
43.	Do you get frequent muscle cramps when exercising?		
44.	Have you had any problems with your eyes or vision?		
45.	Have you had any eye injuries?		
46.	Do you wear glasses or contact lenses?		
47.	Do you wear protective eyewear, such as goggles or a face shield?		
48.	Have you ever had hearing loss or problems with your hearing?		
49.	Do you worry about your weight?		
50.	Are you trying to or has anyone recommended that you gain or lose weight?		
51.	Are you on a special diet or do you avoid certain types of foods?		
52.	Have you ever had an eating disorder?		
53.	Do you have any concerns that you would like to discuss with a doctor?		
54.	Do you have any other medical problems?		
FEMALES ONLY		**Yes**	**No**
55.	Have you ever had a menstrual period?		
56.	Have you had any problems with your periods (severe cramps, heavy bleeding?		
57.	When was your last period? _____		
58.	What is the frequency of your periods? _____		

Explain "yes" answers here

I have reviewed the History Form and I hereby state that, to the best of my knowledge, the answers to the above questions are complete and correct. I give permission for _____ (**Child's Name**) to have a physical examination, which will include an inguinal and testicular examination for boys and an inguinal examination for girls. If this exam is performed in the school setting, I understand that if either I or my child refuses to have these areas examined, the OSH Medical provider will not be able to complete this form and clear my child for participation.

Parent/Guardian Name	
Parent/Guardian Signature	Date
Phone #	

PSAL Health History COVID Addendum

(to be completed and signed by parent/guardian within 30 days before sports participation)

COVID-19 Information (Check Yes or No for each question)	YES	NO
1. Has your child ever tested positive for COVID-19?		
2. Did your child ever have symptoms of COVID-19 infection? (Symptoms could include fever, chills, fatigue, body aches, new loss of smell or taste, unexplained cough, shortness of breath or trouble breathing)		
3. Did your child ever see a healthcare provider (HCP) for COVID-19 symptoms?		
4. Did your child have any of the symptoms below? (If yes, please add more information.)		
-New fast or slow heart rate		
-Chest pain or tightness		
-New or unexplained fainting or fatigue		
-A new heart condition or blood pressure changes diagnosed by a health care provider		
If yes, is your child under a health care provider's care for this?		
5 Was your child hospitalized? If yes, provide date(s):		
If yes, was your child diagnosed with Multisystem Inflammatory syndrome (MISC)?		
If yes, is your child under a health care provider's care for this?		

Please explain fully any question you answered yes to in the space below, include dates if known.
Use additional pages if necessary.

_____

_____

_____

Parent/Guardian Signature: _____ Date: _____

Adapted from the NYS Center for School Health located at www.schoolhealthny.com –12/2020
REV. 3/21

PHYSICAL EXAMINATION FORM | Preparticipation Physical Evaluation

NOTE: The medical provider should keep this form in the student's medical file. This form does not get returned to the athletic department.

Last Name	First Name	Date of Birth

School/Campus/ATSDBN	Grade	OSIS#

STUDENT'S HISTORY FORM REVIEWED BY MEDICAL PROVIDER	**YES NO**
PHYSICIAN REMINDER - Consider the questions below	**COMMENTS**
Do you feel safe at your home or residence?	
Do you feel safe at school?	
Do you ever feel stressed out or under a lot of pressure?	
Do you ever feel sad, hopeless, depressed, or anxious?	
Have there been any changes in your weight?	
Have you ever taken any supplements to help you gain or lose weight or improve your performance?	
Have you ever taken anabolic steroids or used any other performance supplement?	
Have you ever tried cigarettes, alcohol, or other drugs?	
During the past 30 days, did you use cigarettes, alcohol or other drugs?	
Are you sexually active?	
Are you using contraceptives?	
Do you wear a seat belt?	

EXAMINATION

Height	Weight	❑ Male ❑ Female

BP	Pulse	Vision	Corrected
_____ / _____		R20/ _____ L20/ _____	❑ Yes ❑ No

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		

MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back (including scoliosis screening)		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a] Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.[b] GU exam must be done in a private setting; the presence of a third party/chaperone is needed. It should not be performed in mass participation settings. [c]consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion. I have examined the above named student and completed the pre-participation physical examination. The athlete may/may not participate in the sport(s) outlined on the Recommendations for Participation in Physical Education and Sports form.
This form may be rescinded until the potential consequences of the health issue are explained to both the student and his/her parents, and the health issue has been resolved. All information and recommendations contained herein are valid through the last day of the month for 12 months from the date below.

Name of medical provider (print/type)	Date	License/NPI Number
Address	Phone	
Signature of Medical Provider ,MD/DO/NP/PA		STAMP HERE

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION & SPORTS

To be completed by student's health care provider or school medical provider

This page must be submitted to coach or athletic director before PSAL participation.

Last Name	First Name	OSIS#	Grade

School/Campus/ATSDBN

❑ **CLEARED FOR ALL SPORTS WITHOUT RESTRICTION**

❑ **NOT CLEARED** **Duration:** _____

❑ **NOT CLEARED PENDING FURTHER EVALUATION** _____

❑ **CLEARED FOR ALL SPORTS WITHOUT RESTRICTION WITH RECOMMENDATIONS FOR FURTHER EVALUATION OR TREATMENT FOR:** _____

❑ **CLEARED WITH RESTRICTIONS/ADAPTATIONS/ACCOMMODATIONS** **Duration:** _____

❑ **NO CONTACT SPORTS:** includes basketball, competitive cheerleading, diving, field hockey, football (tackle), gymnastics, ice hockey, lacrosse, rugby, soccer, stunt, wrestling

❑ **NO LIMITED CONTACT SPORTS:** includes baseball, cross-country skiing, fencing, flag football, handball, high jump, ice skating, pole vault, skiing, softball, volleyball

❑ **NO NON-CONTACT SPORTS:** includes archery, badminton, bowling, cricket, discus, double dutch, golf, javelin, race walking, rifle, shot-put, swimming, table tennis, tennis, track & field

❑ **OTHER RESTRICTIONS** _____

ACCOMMODATIONS/PROTECTIVE EQUIPMENT

❑ None ❑ Athletic Cup ❑ Sports/Safety Goggles ❑ Medical/Prosthetic Device ❑ Pacemaker ❑ Insulin Pump/Insulin Sensor
❑ Brace/Orthotic ❑ Hearing Aides ❑ Protective Ear Gear ❑ Other _____

❑ **PERTINENT MEDICAL HISTORY** _____

❑ **ALLERGIES** _____ ❑ None

MEDICATIONS

❑ Has prescribed pre-exercise medication _____

❑ Has prescribed PRN medication _____

❑ Student is Self-Carry/Self-Administer, **unless in an emergency or student is incapable of self-administration**

Explanation _____

❑ **OTHER RECOMMENDATIONS** _____

I have examined the above named student and completed the pre-participation physical examination, INCLUDING A REVIEW OF ANY MEDICAL HISTORY RELATED TO COVID-19. The athlete may/may not participate in the sport(s) as outlined above. A copy of the physical exam will be provided to the school medical room staff and can be made available to the school administration at the request of the parents. This form may be rescinded: by a medical provider if there are any changes in the student's health that could affect his/her safe participation in sports, and/or until the potential consequences of the health issue are explained to both the student and his/her parents, and the health issue has been resolved. All information and recommendations contained herein are valid through the last day of the month for 12 months from the date below.

Name of medical provider (print/type)	Title	License/NPI

Address	Medical Provider's Stamp

Phone	Fax	Email

Signature of medical provider	Date