

CENTRAL WASHINGTON UNIVERSITY

PRE-PARTICIPATION PHYSICAL EVALUATION FOR ATHLETICS

DATE OF EXAM: _____ SPORT: _____
 Name: _____ Sex: [] M [] F Age: _____ Date of Birth: _____
 Address: _____
 Phone: _____ SIS: _____

Class Standing: [] Freshman [] Sophomore [] Junior [] Senior

- [] Yes [] No Have you had an illness or injury in the past year?
- [] Yes [] No Do you, or have you had an ongoing or chronic illness or injury?
- [] Yes [] No Have you ever been hospitalized overnight?
- [] Yes [] No Do you take any prescription or over-the-counter medications (including inhalers)?
- [] Yes [] No Are you taking any herbal medications or supplements (e.g. to gain or lose weight or to improve performance)?
- [] Yes [] No Do you have any allergies (for example, to pollen, medicine, foods, or stinging insects)?
- [] Yes [] No Have you ever passed out during or after exercise?
- [] Yes [] No Have you ever been dizzy during or after exercise?
- [] Yes [] No Have you ever had chest pain during or after exercise?
- [] Yes [] No Do you get tired more quickly or have a harder time breathing than your friends during exercise?
- [] Yes [] No Have you ever had racing of your heart or skipped heart beats?
- [] Yes [] No Have you ever had high blood pressure?
- [] Yes [] No Have you ever been told you have a heart murmur?
- [] Yes [] No Has any family member or relative died of heart problems or sudden death before age 50?
- [] Yes [] No Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or hives)?
- [] Yes [] No Have you ever had a head injury or concussion (knocked out or confused)?
- [] Yes [] No Have you ever had a seizure?
- [] Yes [] No Do you have frequent or severe headaches?
- [] Yes [] No Have you ever had a stinger, burner, or pinched nerve?
- [] Yes [] No Have you ever become ill from exercising in the heat?
- [] Yes [] No Do you ever cough, wheeze, or have trouble breathing during or after exercise?
- [] Yes [] No Do you have any special braces, retainers, orthotics, or other devices?
- [] Yes [] No Have you had problems with your eyes or vision?
- [] Yes [] No Do you have any trouble hearing?
- [] Yes [] No Have you broken or fractured any bones, or dislocated any joints?
- [] Yes [] No Have you had any problems with pain or swelling in muscles, tendons, bones, or joints?
- [] Yes [] No Do you want to weigh more or less than you do now?
- [] Yes [] No Do you lose weight regularly to meet weight requirements for your sport(s)?
- [] Yes [] No Do you have a single eye or kidney?
- [] Yes [] No Do you smoke or chew tobacco?
- [] Yes [] No Do you regularly consume alcohol?
- [] Yes [] No Do you use marijuana or any other substances?
- [] Yes [] No Do you have any health concerns about trying out for this sport?
- [] Yes [] No Do you have regular menstrual periods? (*FEMALES ONLY*)

Explain "Yes" answers below:

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I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. I authorize the release of this physical exam to the Central Washington University Athletic Department.

Athlete's Signature: _____ Date: _____

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|---------------|--------|-------|-------|-----------|---------------------|------------------------|-----------------------------|
| Height | Weight | Temp. | Pulse | BP | Vision L20/ R20/ | Corrected L20/ R20/ | Glasses [] Contacts [] |
| Current Meds. | | | | Allergies | | | |

(describe findings below, referring to item number)

| Normal | | Abnormal | |
|--------------------------|----------------------------------|--------------------------|--|
| <input type="checkbox"/> | 1. Head | <input type="checkbox"/> | |
| <input type="checkbox"/> | 2. Eyes (pupils), ENT | <input type="checkbox"/> | |
| <input type="checkbox"/> | 3. Teeth | <input type="checkbox"/> | |
| <input type="checkbox"/> | 4. Chest | <input type="checkbox"/> | |
| <input type="checkbox"/> | 5. Lungs | <input type="checkbox"/> | |
| <input type="checkbox"/> | 6. Heart | <input type="checkbox"/> | |
| <input type="checkbox"/> | 7. Abdomen | <input type="checkbox"/> | |
| <input type="checkbox"/> | 8. Genitalia (male only) | <input type="checkbox"/> | |
| <input type="checkbox"/> | 9. Neurologic | <input type="checkbox"/> | |
| <input type="checkbox"/> | 10. Skin | <input type="checkbox"/> | |
| <input type="checkbox"/> | 11. Spine, back, neck | <input type="checkbox"/> | |
| <input type="checkbox"/> | 12. Shoulders, upper extremities | <input type="checkbox"/> | |
| <input type="checkbox"/> | 13. Lower extremities | <input type="checkbox"/> | |
| <input type="checkbox"/> | 14. HCT | <input type="checkbox"/> | |
| <input type="checkbox"/> | 15. UA | <input type="checkbox"/> | |

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Yes No Sports participation approved
 Yes No Approved with the following recommendation(s): _____

Provider Name (print/type): _____

Address: _____

Provider Signature: _____ Date: _____