PREPARTICIPATION PHYSICAL EVALUATION
PHYSICAL EXAMINATION FORM

Today's Date _____

Name _____ ○ M ○ F

Date of Birth _____

PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

Height (in) _____ BP _____

Weight (lb) _____ Pulse _____

Vision R 20/_____ L 20/ _____

Corrected? ○ Y ○ N

EXAMINATION

NORMAL	MEDICAL	ABNORMAL FINDINGS
☐	Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)	
☐	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	
☐	Neck	
☐	Back	
☐	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]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

○ Cleared for all sports without restriction

○ Cleared for all sports without restriction with recommendations for further evaluation or treatment for:

○ Not cleared:
- ○ Pending further evaluation
- ○ For any sports
- ○ For certain sports

Explanation and Recommendations if not cleared for all sports:

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Physician Name _____ Signature of physician X _____ Date _____

Watertown Family Practice
127 Hospital Drive
Watertown Wisconsin 53098
920-261-8500 (T)
920-261-8828 (F)

PREPARTICIPATION PHYSICAL EVALUATION
CLEARANCE FORM

WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION – ATHLETIC PERMIT CARD

(Print or Type)

ALL STUDENTS PARTICIPATING IN INTERSCHOLASTIC ATHLETICS MUST HAVE THIS CARD ON FILE AT THEIR SCHOOL PRIOR TO PRACTICE OR PARTICIPATION

Physical examination taken April 1 and thereafter is valid for the following two school years; physical examination taken before April 1 is valid only for the remainder of that school year and the following school year.

NAME: _____ Date of Birth _____

Age _____ Sex _____ Grade _____ School _____ City _____

Present Address _____ Telephone _____

- ◯ **Cleared without restriction**
- ◯ **Cleared, with the following qualifications:** _____
- ◯ **Not cleared:**
  - ◯ **Pending further evaluation**
  - ◯ **For all sports**
  - ◯ **For certain sports**

Explanation and Recommendations if not cleared for all sports:

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

SIGNATURE OF LICENSED PHYSICIAN (MD OR DO)/PA/APNP*: X _____ Date _____

Name of Physician: _____

Watertown Family Practice
127 Hospital Drive
Watertown Wisconsin 53098
920-261-8500 (T)
920-261-8828 (F)

Reset | Save | Print | Email

Parents' Place of Employment _____

Family Physician _____ Family Dentist _____

Name of Private Insurance Carrier _____ Telephone _____

Subscriber Member Name (Primary Insured) _____

Emergency Information

Allergies _____

Other Information (medication, etc.) _____

Immunizations ❑ **Up to date (see attached documentation)** ❑ **Not up to date - specify** _____
(e.g., tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; poliomyelitis; pneumococcal; meningococcal; varicella)

1. I hereby give my permission for the above named student to practice and compete and represent the school in WIAA approved interscholastic sports except those restricted on this card.

2. Pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder (collectively known as "HIPAA"), I authorize health care providers of the student named above, including emergency medical personnel and other similarly trained professionals that may be attending an interscholastic event or practice, to disclose/exchange essential medical information regarding the injury and treatment of this student to appropriate school district personnel such as but not limited to: Principal, Athletic Director, Athletic Trainer, Team Physician, Team Coach, Administrative Assistant to the Athletic Director and/or other professional health care providers, for purposes of treatment, emergency care and injury record-keeping.

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____