

Cheerleading & Stunt  
**PREPARTICIPATION PHYSICAL EVALUATION**

Date of Exam \_\_\_\_\_

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Personal Physician \_\_\_\_\_

In case of Emergency, Contact:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
1. Have you had a medical illness or injury since your last check up or sports physical?	___	___	26. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (i.e. knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	___	___
2. Have you ever been hospitalized overnight?	___	___	27. Have you had any problems with your eyes or vision?	___	___
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills, or using an inhaler?	___	___	28. Have you ever had a sprain, strain, or swelling after injury?	___	___
4. Do you have any allergies (i.e. to pollen, medicine, food, or stinging insects)?	___	___	29. Have you broken or fractured any bones or dislocated any joints?	___	___
<b>5. Have you ever passed out during or after exercise?</b>	___	___	30. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	___	___
<b>6. Have you ever been dizzy during or after exercise?</b>	___	___	If yes, check appropriate box and explain below:	___	___
7. Have you ever had chest pain during or after exercise?	___	___	___ Head	___ Elbow	___ Hip
8. Do you get tired more quickly than your friends do during exercise?	___	___	___ Neck	___ Forearm	___ Thigh
9. Have you ever had racing of your heart or skipped heartbeats?	___	___	___ Back	___ Wrist	___ Knee
10. Have you had high blood pressure or high cholesterol?	___	___	___ Chest	___ Hand	___ Shin/calf
11. Have you ever been told you have a heart murmur?	___	___	___ Shoulder	___ Finger	___ Ankle
12. Has any family member or relative died of heart problems or of sudden death before age 50?	___	___	___ Upper arm	___ Foot	
13. Have you had a severe viral infection (i.e. myocarditis or mononucleosis) within the last month?	___	___			
<b>14. Has a physician ever denied or restricted your participation in sports for any heart problems?</b>	___	___	31. Do you want to weigh more or less than you do now?	___	___
15. Do you have any current skin problems (i.e. itching, rashes, acne, warts, fungus, or blisters)?	___	___	32. Do you feel stressed out?	___	___
<b>16. Have you ever had a head injury or concussion?</b>	___	___	33. Record the dates of your most recent immunizations (shots) for:		
<b>17. Have you ever been knocked out, become unconscious, or lost your memory?</b>	___	___	Tetanus _____	Measles _____	
18. Have you ever had a seizure?	___	___	Hepatitis B _____	Chickenpox _____	
19. Do you have frequent or severe headaches?	___	___			
20. Have you ever had numbness or tingling in your arms, hands, legs, or feet?	___	___	<b>FEMALES ONLY</b>		
21. Have you ever had a stinger, burner or pinched nerve?	___	___	34. When was your first menstrual period? _____		
22. Have you ever become ill from exercising in the heat?	___	___	35. When was your most recent menstrual period? _____		
23. Do you cough, wheeze or have trouble breathing during or after activity?	___	___	36. How much time do you usually have from the start of one period to the start of another? _____		
24. Do you have asthma?	___	___	37. How many periods have you had in the last year? _____		
25. Do you have seasonal allergies that require medical treatment?	___	___	38. What was the longest time between periods in the last year? _____		

**Explain "Yes" answers here:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

Signature of Athlete \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

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**PREPARTICIPATION PHYSICAL EVALUATION**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ %Body fat (optional) \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_ ( \_\_\_\_\_ / \_\_\_\_\_ , \_\_\_\_\_ / \_\_\_\_\_ )

Vision R 20/	L 20/	Corrected: Y N	Pupils Equal	Unequal	
<b>MEDICAL</b>	<b>NORMAL</b>	<b>ABNORMAL FINDINGS</b>			<b>INITIALS*</b>
Appearance					
Eyes/Ears/Nose/Throat					
Lymph Nodes					
Heart					
Pulses					
Lungs					
Abdomen					
Genitalia (males only)					
Skin					
<b>MUSCULOSKELETAL</b>					
Neck					
Back					
Shoulder/Arm					
Elbow/Forearm					
Wrist/Hand					
Hip/Thigh					
Knee					
Leg/Ankle//Foot					

\_\_\_\_\_ **Cleared** (This includes no restrictions for full contact sports, if restrictions, please specify below)  
 \_\_\_\_\_ **Cleared after completing evaluation/rehabilitation for:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_ **Not cleared for:** \_\_\_\_\_ **Reason:** \_\_\_\_\_

Recommendations: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Name of Physician (Print/Type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of Physician \_\_\_\_\_ MD ; DO; DC

Physician's Stamp:

