Has a doctor ever told you that you cannot compete in sports for any reason? (please circle): Yes  No
Do you have any ongoing medical conditions (like asthma, diabetes, other)? Yes  No
Are you missing a kidney, eye, a testicle (males), spleen, or any other organ? Yes  No
Do you have any allergies to medicine, food, or insects? Yes  No
If yes, list reaction: ________________________________
Are you currently taking any medicine or supplements? Yes  No
Medicine: ________________________________Reason for taking it: ________________________________
Medicine: ________________________________Reason for taking it: ________________________________
Have you ever had mononucleosis? Yes  No
Date: ________________________________
Have you ever had COVID-19? Yes  No
Date: ________________________________
Do you have any other medical issues - either now or in the past? Yes  No
Explain any YES answer: ________________________________

Family History

Are there any family members who died before age 50? Yes  No
Please list any other major medical problems affecting your parents, brothers, or sisters:

Are there any family members with conditions that can affect the heart such as:

Enlarged heart Yes  No
Hypertrophic Cardiomyopathy Yes  No
Dilated Cardiomyopathy Yes  No
Long QT syndrome Yes  No
Short QT syndrome Yes  No
Brugada syndrome Yes  No
Catecholaminergic Polymorphic Ventricular Tachycardia Yes  No
Arrhythmogenic Right Ventricular Cardiomyopathy Yes  No
Marfan syndrome Yes  No
Heart attack, age 50 or younger Yes  No
Pacemaker or defibrillator, age 50 or younger Yes  No
Your Cardiac History

Have you ever been dizzy during or after exercise? Yes No
Have you ever passed out during or after exercise? Yes No
Have you ever had chest pain with exercise? Yes No
Does your heart race or skip beats during exercise? Yes No
Do you ever get short of breath with exercise? Yes No
Do you get tired or short of breath more quickly than your friends? Yes No
Has a doctor ever ordered a heart test (EKG, Echo)? Yes No

Have you ever been told that you have:
a heart murmur? Yes No
high blood pressure? Yes No
a heart infection (myocarditis)? Yes No
Kawasaki disease? Yes No
high cholesterol? Yes No

Concussion/Neurologic History

Have you ever had a head injury, concussion, saw stars, had your “bell rung”? Yes No
If yes, when (approximate date(s)): ____________________________
If yes, have you 100% fully recovered? Yes No
Have you ever been knocked out, blacked out, or unconscious? Yes No
Have you ever had a stinger or burner? Yes No
Have you ever lost feeling or couldn't move an arm or leg? Yes No
Have you ever had a seizure? Yes No

Respiratory History

Do you have asthma? Yes No
If yes, how often do you use Albuterol inhaler or “puffer” (circle):
throughout the day | once a day | more than 2 days/week | less than 2 days/week | exercise only
Do you cough, wheeze, or have trouble breathing during or after exercise? Yes No
Have you ever been given a daily medication for asthma or breathing issues? Yes No

Heat Illness History

Have you ever had any exercise related heat cramps or heat stroke? Yes No
Have you ever needed to get IV Fluids due to the heat? Yes No
Behavioral Health Screening

In the last 2 weeks, how often have you been bothered by any of the following problems? (circle)

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Some days</th>
<th>Most days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling nervous, anxious, or on edge</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Not being able to stop or control worrying</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Do you make yourself sick because you feel uncomfortably full? Yes No
So you worry you have lost control over how much you eat? Yes No
Have you recently lost more than 14 pounds in a three month period? Yes No
Do you believe yourself fat when others say you are too thin? Yes No
Would you say that food dominates your life? Yes No

Circle the answer that best applies to you:

<table>
<thead>
<tr>
<th>How often do you have a drink containing alcohol?</th>
<th>Never</th>
<th>Monthly or less</th>
<th>2-3 times a month</th>
<th>2-3 times a week</th>
<th>4 + times a week</th>
</tr>
</thead>
<tbody>
<tr>
<td>How many standard drinks do you have on a typical day when drinking?</td>
<td>1 or 2</td>
<td>3 or 4</td>
<td>5 or 6</td>
<td>7 to 9</td>
<td>10 +</td>
</tr>
<tr>
<td>How often do you have 6 or more drinks?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily</td>
</tr>
</tbody>
</table>

Do you use tobacco? Yes No
If yes: Type (vape/cigarettes/chew)?

Do you use marijuana? Yes No
If yes: Type (vape/smoke)?

Sexual History

Have you ever had sexual activity another person? Yes No
If yes:
When you have engaged in sexual activity, what sex has/have your sexual partner(s) been? (circle)
- Opposite sex (male with female, female with male)
- Same sex (female with female, male with male)
- Multiple sexes (sometimes called bisexual/pansexual)

How many different sexual partners have you had:
- In the past year: __________________________
- In your entire life: ________________________

Have you ever been diagnosed with a sexually transmitted infection? Yes No
If yes, which infection(s)? __________________________

Do use condoms or barriers for sexual activity? Always Sometimes Never
Vaccine History

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Received</th>
<th>Year</th>
<th>HPV</th>
<th>Received</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus (within 10 years)</td>
<td>Y / N</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Menigitis ACWY (booster after 16)</td>
<td>Y / N</td>
<td></td>
<td>HPV</td>
<td>Y / N</td>
<td></td>
</tr>
<tr>
<td>Menigits B (up to age 24)</td>
<td>Y / N</td>
<td></td>
<td>COVID-19</td>
<td>Y / N</td>
<td></td>
</tr>
</tbody>
</table>

Injury History

Please list any significant injuries (symptoms or time off for more than 1 week):

<table>
<thead>
<tr>
<th>Body Region</th>
<th>Sprain / Strain / Fracture / Other</th>
<th>Year</th>
<th>Right / Left</th>
<th>Management / Treatment / Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neck/Back</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hand/Wrist</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elbow</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shoulder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hip</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knee</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ankle</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foot</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Student signature: ___________________________ Date: ___________________________
I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the student. If conditions arise after the athlete has been cleared for participation, the clinician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the student.

Name of health care professional (print or type): ________________________________

Credential (circle): MD DO NP

Clinic Name: ________________________________

Address: ________________________________

Phone: ________________________________

Signature of clinician: ________________________________ Date: ____________