CANEY VALLEY RECREATION PHYSICAL EVALUATION

CVRC
CANEY VALLEY RECREATION COMMISSION

TO BE COMPLETED ANNUALLY BY EVERY PARTICIPANT AND PARENT OR GUARDIAN

Name Sex: Male/Female Age Date of Birth

Grade School Sport(s)

Address Phone ( )

Personal Physician

In case of emergency, contact:

Name Relationship Phone

STUDENT/PARENT/GUARDIAN - answer questions below PRIOR TO EXAMINATION by physician. Explain "YES" answer in space below. Circle the number of the questions you do not know.

	YES	NO	
1.	☐	☐	Have you had a medical illness or injury since your last check or sports physical?
2.	☐	☐	Do you have an ongoing or chronic illness?
3.	☐	☐	Have you ever been hospitalized overnight?
4.	☐	☐	Have you ever had surgery?
5.	☐	☐	Are you currently taking any prescription or non - prescription (over the counter- OTC) medications or pills or using an inhaler?
6.	☐	☐	Have you ever taken any supplements or vitamins to help you lose weight or improve your performance?
7.	☐	☐	Do you have any allergies (for example, to pollen, medication, food or stinging insects)? Have you ever has a rash or hives develop during or after exercise?
8.	☐	☐	Have you ever passed out during or after exercise?
9.	☐	☐	Have you ever been dizzy during or after exercise?
10.	☐	☐	Have you ever had chest pain during or after exercise?
11.	☐	☐	Do you get tired more quickly than your friends do during exercise?
12.	☐	☐	Have you ever had racing of your heart or skipped heartbeats?
13.	☐	☐	Have you had high blood pressure or high cholesterol?
14.	☐	☐	Have you ever been told you have a heart murmur?
15.	☐	☐	Has any family member or relative died of heart problems or of sudden death before age 50?
16.	☐	☐	Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?
17.	☐	☐	Has a physician ever denied or restricted your participation in sports for any heart problems?
18.	☐	☐	Do you have any current skin problems (for example itching, tashes, acne, warts, fungus, or blisters)
19.	☐	☐	Have you ever had a head injury or concussion? *Please explain in the YES area*
20.	☐	☐	Have you ever been knocked out, become unconscious, or lost your memory?
21.	☐	☐	Have you ever had a seizure?
22.	☐	☐	Have you ever had numbness or tingling in your arms, hands, legs, or feet?
23.	☐	☐	Have you ever has a stinger, burner, or pinched nerve?
24.	☐	☐	Have you ever become ill from exercising in the heat?
25.	☐	☐	Do you cough, wheeze, or have trouble breathing during or after activity?
26.	☐	☐	Do you have asthma?
27.	☐	☐	Do you have seasonal allergies requiring medical treatment?
28.	☐	☐	Do you use any special protective or corrective equipment or devices that aren't usually use for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?
29.	☐	☐	Do you want to weight more or less than you do now?
30.	☐	☐	Do you lose weight regularly to meet weight requirements for your sport?
31.	☐	☐	Have you had any problems with your eyes or vision?
32.	☐	☐	Do you wear glasses, contacts, or protective eyewear?
33.	☐	☐	Have you ever has a sprain, strain, fracture or dislocation of a muscle, tendon, bone or joint?

If yes, check appropriate box and explain below.

☐ Head	☐ Shoulder	☐ Wrist	☐ Thigh
☐ Neck	☐ Upper Arm	☐ Hand	☐ Knee
☐ Back	☐ Elbow	☐ Finger	☐ Shin/calf
☐ Chest	☐ Forearm	☐ Hip	☐ Ankle
			☐ Foot

FEMALES ONLY

34. ☐ ☐ Have you begun menstruation?

If yes, are you ever experiencing any problem (i.e. irregularity, pain, ect)?

IDENTIFY "YES"ANSWERS (by number)

_____

_____

_____

_____

Signature of Parent or Guardian_____**Date**_____

PRE-PARTICIPATION PHYSICAL EVALUATION

Name **Date of Birth**

Height **Weight** **Tanner Stage I II III IV V** **Pulse** **BP**

Vision **R 20/** **L20/** **Corrected: Y N** **Pupils: Equal Unequal**

Record date of most recent immunizations (shot) for Td

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS*
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulse			
Lungs			
Abdomen			
Genitalia/Hernia			
Skin			

MUSCULOSKELETAL

Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

CLEARANCE

☐ Cleared for all activities

☐ Not cleared for: _____

Reason: _____

Recommendations: _____

I HEREBY CERTIFY THAT I AM QUALIFIED BY TRAINING AND EXPERIENCE TO PROPERLY PERFORM THE EXAMINATION AND MAKE THE EVALUATION REFLECTED ON THIS FORM

Name of physician (Print) _____ Date _____

Address _____ Phone ( )

Signature of Physician _____ MD DO DC APRN