

Johnson County Healthcare Center Pre-Participation Physical Evaluation

**Parents – Please fill in the form down to the dotted line
with your child before the physical exam:**

School _____ Grade _____ Male _____ Female _____
 Full Name _____
 Address _____ Phone _____
 Birth Date _____ Sports _____
 Ongoing or chronic illness _____
 Surgeries _____
 List all prescription or over the counter drugs/medicines you are taking _____
 Allergies: Medical _____
 Environmental _____

Yes	No	Have you ever had chest pain, dizziness, or loss of consciousness while or shortly after exercising?
		Do you have a heart murmur?
		Has a family member died suddenly before age 50? Explain:
		Has a physician ever denied or restricted your sports participation?
		Are your immunizations up to date?
		Have you ever had a concussion?
		Have you ever had a seizure?
		Have you ever had a fracture?
		Have you ever had a dislocation? Where? When?
		Do you have any pain or swelling? Where?
Females: How many menstrual periods have you had in the past year?		
Date of your last menstrual period:		

FOR DOCTOR'S USE ONLY PHYSICAL EXAMINATION RECORD

Height _____ Weight _____

Code 0 – normal 1- remedial defect 2 – defect, but no other treatment necessary

1. Blood Pressure /	8. Skin	15. Hernia
2. Pulse, Resting	9. Throat and Tonsils	16. Genitalia
3. Pulse, Exercise	10. Nose	17. Arms & Hands
4. Vision R20/ L20/	11. Lymph Nodes	18. Legs & Feet
5. Pupils	12. Heart	19. Spine
6. Ears	13. Lungs	20. Posture
7. Teeth	14. Abdomen	21. Other

Physical Activity: Unrestricted _____ Modified _____

Reason _____

Recommendations _____

Signature of Physician _____ Date _____