



# PREPARTICIPATION PHYSICAL EVALUATION (Page 1 of 4)

*This medical history form should be retained by the healthcare provider and/or parent and not turned into the school.*

*This form is valid for 365 calendar days from the date signed below.*

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Revised 6/25

## MEDICAL HISTORY FORM

### Student Information (to be completed by student and parent) *print legibly*

Student's Full Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Home Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_ E-mail: \_\_\_\_\_

Person to Contact in Case of Emergency: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Emergency Contact Cell Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Other Phone: (\_\_\_\_) \_\_\_\_\_

Family Healthcare Provider: \_\_\_\_\_ City/State: \_\_\_\_\_ Office Phone: (\_\_\_\_) \_\_\_\_\_

List past and current medical conditions:

Have you ever had surgery? If yes, please list all surgical procedures and dates:

Medicines and supplements (please list all current prescription medications, over-the-counter medicines, and supplements (herbal and nutritional):

Do you have any allergies? If yes, please list all of your allergies (i.e., medicines, pollens, food, insects):

### Patient Health Questionnaire version 4 (PHQ-4)

*Over the past two weeks, how often have you been bothered by any of the following problems? (Circle response)*

|                                             | Not at all | Several days | Over half of the days | Nearly everyday |
|---------------------------------------------|------------|--------------|-----------------------|-----------------|
| Feeling nervous, anxious, or on edge        | 0          | 1            | 2                     | 3               |
| Not being able to stop or control worrying  | 0          | 1            | 2                     | 3               |
| Little interest or pleasure in doing things | 0          | 1            | 2                     | 3               |
| Feeling down, depressed, or hopeless        | 0          | 1            | 2                     | 3               |

**Mental Health Immediate Resources:** Colorado Crisis <https://coloradocrisisservices.org/> Call/text 988 or live chat at [988Colorado.com](https://988Colorado.com).  
 For additional Mental Health Resources, Please go to <https://chsaanow.com/sports/2021/7/22/smac.aspx>

| GENERAL QUESTIONS                |                                                                                                    | Yes | No | HEART HEALTH QUESTIONS ABOUT YOU<br>(continued) |                                                                                                                                                                                                                                                                                                                   | Yes | No |
|----------------------------------|----------------------------------------------------------------------------------------------------|-----|----|-------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| 1                                | Do you have any concerns that you would like to discuss with your provider?                        |     |    | 8                                               | Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography (ECHO)?                                                                                                                                                                                             |     |    |
| 2                                | Has a provider ever denied or restricted your participation in sports for any reason?              |     |    | 9                                               | Do you get light-headed or feel shorter of breath than your friends during exercise?                                                                                                                                                                                                                              |     |    |
| 3                                | Do you have any ongoing medical issues or recent illnesses?                                        |     |    | 10                                              | Have you ever had a seizure?                                                                                                                                                                                                                                                                                      |     |    |
| HEART HEALTH QUESTIONS ABOUT YOU |                                                                                                    | Yes | No | HEART HEALTH QUESTIONS ABOUT YOUR FAMILY        |                                                                                                                                                                                                                                                                                                                   | Yes | No |
| 4                                | Have you ever passed out or nearly passed out during or after exercise?                            |     |    | 11                                              | Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35? (including drowning or unexplained car crash)                                                                                                                                            |     |    |
| 5                                | Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?          |     |    | 12                                              | Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan Syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)? |     |    |
| 6                                | Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise? |     |    | 13                                              | Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?                                                                                                                                                                                                                            |     |    |
| 7                                | Has a doctor ever told you that you have any heart problems?                                       |     |    |                                                 |                                                                                                                                                                                                                                                                                                                   |     |    |



## PREPARTICIPATION PHYSICAL EVALUATION (Page 2 of 4)

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Revised 6/25

Student's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ School: \_\_\_\_\_

| BONE AND JOINT QUESTIONS |                                                                                                            | Yes | No |
|--------------------------|------------------------------------------------------------------------------------------------------------|-----|----|
| 14                       | Have you ever had a stress fracture?                                                                       |     |    |
| 15                       | Did you ever injure a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game? |     |    |
| 16                       | Do you have a bone, muscle, ligament, or joint injury that currently bothers you?                          |     |    |

| MEDICAL QUESTIONS |                                                                                                                                                   | Yes | No |
|-------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| 17                | Do you cough, wheeze, or have difficulty breathing during or after exercise or has a provider ever diagnosed you with asthma?                     |     |    |
| 18                | Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?                                                                    |     |    |
| 19                | Do you have groin or testicle pain or a painful bulge or hernia in the groin area?                                                                |     |    |
| 20                | Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant staphylococcus aureus (MRSA)?         |     |    |
| 21                | Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?                                         |     |    |
| 22                | Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling? |     |    |
| 23                | Have you ever become ill while exercising in the heat?                                                                                            |     |    |
| 24                | Do you or does someone in your family have sickle cell trait or disease?                                                                          |     |    |
| 25                | Have you ever had or do you have any problems with your eyes or vision?                                                                           |     |    |

| MEDICAL QUESTIONS (continued) |                                                                                  | Yes | No |
|-------------------------------|----------------------------------------------------------------------------------|-----|----|
| 26                            | Do you worry about your weight?                                                  |     |    |
| 27                            | Are you trying to or has anyone recommended that you gain or lose weight?        |     |    |
| 28                            | Are you on a special diet or do you avoid certain types of foods or food groups? |     |    |
| 29                            | Have you ever had an eating disorder?                                            |     |    |

Explain "Yes" answers here:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Participation in high school sports is not without risk. The student-athlete and parent/guardian acknowledge truthful answers to the above questions allows for a trained clinician to assess the individual student-athlete against risk factors associated with sports-related injuries and death. CHSAA bylaw 1780.1 states, "No pupil shall participate in formal practice or represent his/her/their school in interscholastic athletics until there is a statement on file with the principal or athletic director signed by his/her/their parents or legal guardian and a practitioner licensed in the United States to perform sports physicals certifying that: (a) he/she/they has passed an adequate physical examination within the past 365 calendar days; (b) that in the opinion of the examining licensed practitioner, he/she/they is physically fit to participate in high school athletics; and (c) that he/she/they has the consent of his/her/ their parents or legal guardian to participate. This preparticipation physical evaluation shall be completed each year before participating in interscholastic athletic competition or engaging in any practice, tryout, workout, conditioning, or other physical activity, including activities that occur outside of the school year.

We hereby state, to the best of our knowledge, that our answers to the above questions are complete and correct. No pupil shall participate in formal practice or represent his/her/their school in interscholastic athletics until this form is completed in its entirety and page 4 is on file with the principal or athletic director signed by his/her/their parents or legal guardian and a practitioner licensed in the United States to perform sports physicals certifying that: (a) he/she/they has passed an adequate physical examination within the past 365 calendar days; (b) that in the opinion of the examining licensed practitioner, he/she/they is physically fit to participate in high school athletics. The CHSAA Sports Medicine Advisory Committee strongly recommends a medical evaluation with your healthcare provider for risk factors of sudden cardiac arrest which may include the special tests listed above.

Student-Athlete Name: \_\_\_\_\_ (printed) Student-Athlete Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ (printed) Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ (printed) Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_