

## CONNECTICUT PRE-PARTICIPATION SPORTS EVALUATION

### HISTORY to be filled out by Parent or Student (if over 18)

<table>
<thead>
<tr>
<th>Name</th>
<th>Sex</th>
<th>Age</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
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<table>
<thead>
<tr>
<th>School</th>
<th>Grade</th>
<th>Sport(s)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Personal physician</th>
<th>In case of emergency, contact:</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
</tr>
</tbody>
</table>

Name__________________________________________ Relationship________ Phone (H)____________________ (W)_____________________

In case of emergency, contact:

Name__________________________________________ Phone (H)____________________ (W)_____________________

Explain “yes” answers below. Circle questions you don’t know the answer to.

1. Have you had a medical illness or injury since your last check up or sports physical?
   - [ ] Yes
   - [ ] No

2. Do you have lump(s) in the armpit or groin?
   - [ ] Yes
   - [ ] No

3. Do you have diarrhea more than once a week, or black/bloody bowel movements (stools)?
   - [ ] Yes
   - [ ] No

4. Do you have kidney disease or dark brown bloody urine?
   - [ ] Yes
   - [ ] No

5. Have you ever passed out during or after exercise?
   - [ ] Yes
   - [ ] No

6. Have you ever had a rash or hives develop during or after exercise?
   - [ ] Yes
   - [ ] No

7. Have you ever had a head injury or concussion?
   - [ ] Yes
   - [ ] No

8. Have you ever had chest pain during or after exercise?
   - [ ] Yes
   - [ ] No

9. Have you ever had a medical illness or injury since your last check up or sports physical?
   - [ ] Yes
   - [ ] No

10. Do you have any current skin problems (for example, itching, rash, acne, warts, fungus, or blisters)?
    - [ ] Yes
    - [ ] No

11. Have you ever had a sprain, strain, or swelling after injury?
    - [ ] Yes
    - [ ] No

12. Have you ever had a heart murmur?
    - [ ] Yes
    - [ ] No

13. Have you ever had a rash or hives develop during or after exercise?
    - [ ] Yes
    - [ ] No

14. Have you ever had a rash or hives develop during or after exercise?
    - [ ] Yes
    - [ ] No

15. Do you ever require any medication to control menstrual pain?______
    - [ ] Yes
    - [ ] No

16. When was your first menstrual period?___________________
    - [ ] Yes
    - [ ] No

<table>
<thead>
<tr>
<th>Muscles</th>
<th>Tendons</th>
<th>Bones</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head</td>
<td>Elbow</td>
<td>Wrist</td>
</tr>
<tr>
<td>Shoulder</td>
<td>Wrist</td>
<td>Forearm</td>
</tr>
<tr>
<td>Shin/Calf</td>
<td>Back</td>
<td>Hip</td>
</tr>
<tr>
<td>Ankle</td>
<td>Foot</td>
<td></td>
</tr>
</tbody>
</table>

FEMALES ONLY

17. When was your most recent menstrual period?________
    - [ ] Yes
    - [ ] No

18. What was the longest time between periods in the last year?________
    - [ ] Yes
    - [ ] No

19. When was your most recent menstrual period?________
    - [ ] Yes
    - [ ] No

20. How many periods have you had in the last year?________
    - [ ] Yes
    - [ ] No

21. When was your first menstrual period?___________________
    - [ ] Yes
    - [ ] No

22. When was your most recent menstrual period?________
    - [ ] Yes
    - [ ] No

23. How many periods have you had in the last year?________
    - [ ] Yes
    - [ ] No

24. What was the longest time between periods in the last year?________
    - [ ] Yes
    - [ ] No

25. Do you ever require any medication to control menstrual pain?______
    - [ ] Yes
    - [ ] No

26. Explain “yes” answers here:
    - [ ] Yes
    - [ ] No

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__________
### CONNECTICUT PRE-PARTICIPATION SPORTS EVALUATION

**Physical Examination**

Name: __________________________ Date of Birth: __________________

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>% Body Fat</th>
<th>Pulse</th>
<th>BP</th>
<th>Vision:</th>
<th>Corrected:</th>
<th>Pupils:</th>
</tr>
</thead>
<tbody>
<tr>
<td>______</td>
<td>______</td>
<td>_________</td>
<td>______</td>
<td>___</td>
<td>20 / ___</td>
<td>Y / N</td>
<td>Equal</td>
</tr>
</tbody>
</table>

* Abnormal Findings

<table>
<thead>
<tr>
<th>Medical</th>
<th>Normal</th>
<th>Abnormal Findings</th>
<th>Initials*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appearance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes / Ears / Nose / Throat</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lymph Nodes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lungs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genitalia (males only)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
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</tbody>
</table>

**Musculoskeletal**

<table>
<thead>
<tr>
<th>Neck</th>
<th></th>
<th></th>
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<tbody>
<tr>
<td>Back</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shoulder / Arm</td>
<td></td>
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<tr>
<td>Elbow / Forearm</td>
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<tr>
<td>Wrist / Hand</td>
<td></td>
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<tr>
<td>Hip / Thigh</td>
<td></td>
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</tr>
<tr>
<td>Knee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leg / Ankle</td>
<td></td>
<td></td>
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<tr>
<td>Foot</td>
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</tbody>
</table>

* Station-based examination only

**CLEARANCE**

- [ ] Cleared
- [ ] Cleared after completing evaluation / rehabilitation for:

  [ ] Not cleared for: _________________________________ Reason: _________________________________

**Recommendations:**

- ___________________________________________________
- ___________________________________________________
- ___________________________________________________

Name of physician (print/type): __________________________

Address: __________________________ Telephone: __________

Signature of physician: __________________________ MD or DO