2022 GREENVILLE COUNTY RECREATION
Pre-participation Physical Evaluation Form

Please note that the physical exam must be completed on 1/1/22 or later for a player to be eligible for the fall 2022 Season

Athlete's Name: (print) _____ Sex: _____ Age: _____ Date of Birth:_____

School: _____ Grade: _____ Personal Physician: _____

In Case of Emergency, contact: Name:_____ Phone: _____ Relationship: _____

MEDICAL HISTORY			
Explain "yes" answers in the box below **		**Yes**	**No**
1.	Has a doctor ever denied or restricted your participation in sports for any reason?		x
2.	Do you currently have an ongoing medical condition? ☐ Asthma ☐ Diabetes ☐ Other		x
3.	Are your currently taking any medication (prescription or over-the-counter), pills or an inhaler?		x
4.	Do you have any allergies? (Medicine, bees, food etc.)		x
5.	Do you, or anyone in your family, have the sickle cell trait?		x
6.	Have you ever had a head injury or had a concussion?		x
7.	Have you ever been knocked out, become unconscious, or lost your memory?		x
8.	Have you ever had a seizure?		x
9.	Have you ever had a heat related injury (heat stroke) or severe muscle cramp with activities?		x
10.	Have you ever become ill while exercising in the heat?		x
11.	Have you ever been dizzy during or after exercise?		x
12.	Have you ever passed out or nearly passed out DURING exercise?		x
13.	Have you ever fainted or passed out AFTER exercise?		x
14.	Have you had extreme fatigue (been really tired) with exercise (more than your friends)?		x
15.	Do you ever have trouble breathing, shortness of breath, wheezing or coughing while exercising?		x
16.	Have you ever been diagnosed with Asthma or exercise-induced asthma?		x
17.	Have you ever used an inhaler or taken Asthma medicine?		x
18.	Has a doctor ever told you that you have high blood pressure?		x
19.	Do you have headaches with exercise?		x
20.	Has a doctor ever ordered an EKG or other tests for your heart?		x
21.	Have you ever been told that you have a heart murmur, high cholesterol, or heart infection?		x
22.	Have you ever had discomfort, pain or pressure in your chest during or after exercise?		x
23.	Have you ever had racing of your heart or skipped heartbeats?		x
24.	Have you ever had a stinger, burner or pinched nerve, or loss of feeling or weakness in your arms or legs?		x
25.	Do you have any rashes, pressure sores, or other skin problems now?		x
26.	Have you had any problems with your eyes or vision?		x
27.	Do you wear contacts or glasses?		x
28.	Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injury Of any bones or joints? ☐ Head ☐ Back ☐ Shoulder ☐ Forearm ☐ Hand ☐ Hip ☐ Knee ☐ Ankle ☐ Neck ☐ Chest ☐ Elbow ☐ Wrist ☐ Finger ☐ Thigh ☐ Shin ☐ Foot		X
29.	Do you worry about your weight?		x
30.	Have you ever been hospitalized or had surgery?		x
31.	Have you had a medical problem or injury since your last physical evaluation?		x
32.	Has any family member had a sudden, unexpected death before the age of 50?		x
33.	Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		x
*****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: _____

Office Use Only:

This Medical History Form was reviewed by: Printed Name_____Date:_____Signed_____

Physical Examination 2022 *(Must be Completed by a Licensed Physician, Physician Assistant, or Nurse Practitioner)*

Please note that once this form is given to Greenville County Rec, it will not be returned.

Athlete's Name_____ Sex: M F Age:____ Date of Birth _____

Height_____ ***Weight*** _____ ***BP*** _____/_____ (____/____) ***Pulse*** _____ ***Vision*** R 20/_____ L20/_____

MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin		
Neurologic		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		
Functional		

CLEARANCE

☐ Cleared for all sports without restriction

☐ Cleared after completing evaluation/rehabilitation for: _____

_____

☐ **NOT CLEARED** for participation

Reason:_____

Recommendations:

_____

_____

By this signature, I attest that I have examined the above individual and completed this pre-participation physical including a review of the Medical History.

Physician Name (print): _____

Address:_____

Phone:_____

Physician Signature: _____MD DO NP PA

Date Signed:_____ Date of Exam**_____

Physician Office Stamp:

**Physical will not be accepted without Physician's Office Stamp and/or Full Physician's Address*

*****Physical Exam must be completed on 1/1/22 or later in order to be accepted***