PRE-PARTICIPATION PHYSICAL
PLYMOUTH COMMUNITY SCHOOL CORPORATION

Name: _____ Date: _____

Address: _____ City: _____ Zip: _____

Sex: _____ Age: _____ Date of Birth: _____ Grade: _____ Phone: _____

Personal Physician: _____ Phone: _____

1.	Have you ever been hospitalized?	Yes	No
	Have you ever had surgery?	Yes	No
2.	Are you presently taking any medicine or pills?	Yes	No
3.	Do you have any allergies (medicine, bees or other stinging insects?)	Yes	No
4.	Have you ever passed out during or after exercise?	Yes	No
	Have you ever been dizzy during or after exercise?	Yes	No
	Have you ever had chest pain during or after exercise?	Yes	No
	Have you ever been told you have a heart murmur?	Yes	No
5.	Have you ever had a head injury?	Yes	No
	Have you ever been knocked out or unconscious?	Yes	No
	Have you ever had a seizure or epilepsy?	Yes	No
6.	Have you ever had heat cramps, heat illness or muscle cramps?	Yes	No
7.	Do you have trouble breathing or do you cough during or after activity?	Yes	No
8.	Are you missing an eye, kidney, or testicle?	Yes	No
	Have you had any other medical problems?	Yes	No

Height: _____ Weight: _____ BP: _____ Pulse: _____

Vision: R 20/ _____ L 20/ _____ Corrected ▣ Yes □ No
Pupils: Equal Unequal R>L L>R

	Circle (if option given)	Specific Findings
Marfan's syndrome stigmata	□ Yes ▣ No	
Heart		
Rhythm	□Regular □ Irregular	
Murmur (supine)	□ Yes □ No	
Murmur (standing)	□ Yes □ No	
	Normal (3)	Specific Findings
Lungs		
Skin		
Abdominal		
Femoral Pulses		
Genitalia/Hernia		

Musculoskeletal		
Neck		
Shoulders		
Elbows		
Wrists		
Hands		
Back		
Knees		
Ankles		
Feet		
Other		

PHYSICIAN'S CERTIFICATION

Clearance:

A. Cleared
B. Cleared after completing evaluation/rehabilitation for: _____
C. Not Cleared
Due to: _____

Recommendation:

I hereby certify that this athlete was examined by me. At that time, no physical condition was detected which would reasonably be anticipated to render this athlete physically unfit to engage in any sport, expect those **marked below**:

Boys Sports: ☐ Basketball ☐ Cross country ☐ Football ☐ Golf ☐ Track ☐ Wrestling

Boys Sports: ☐ Basketball ☐ Cheerleading ☐ Cross Country ☐ Golf ☐ Track ☐ Volleyball

Name of Physician: _____ Phone: _____

Address: _____

Signature of Physician: _____ Date: _____

PARENT'S CONSENT

I/we hereby give consent for my son/daughter to participate in all interschool sports at _____ except _____.
(School)

I/we know of and acknowledge that my son/daughter knows of the risks involved in athletic participation. I/we understand that the school cannot assume financial responsibility for hospital and medical costs. Therefore, I/we agree to assume full costs of medical and hospital bills for my son/daughter which is incurred by participation in practice and interschool contests. I/we choose to accept full responsibility for his/her safety and welfare while participating in athletics and hold harmless my school of any and all responsibility and liability for an injury claim resulting from such athletic participation. I/we agree to take legal action because of any accident or mishap involving the athletic participation of my son/daughter.

If school authorities cannot contact me at the time of the accident, I hereby authorize them to contact a physician and/or hospital and request immediate treatment with the understanding that such authorization does not obligate the school for the financial responsibility of the same.

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____