2026-2027 Jenks Athletics
Preparticipation Physical Examination Form-Page 1

ATTENTION: Please submit completed copies of ***both pages*** in person to the Jenks Athletic Department or through email: sports.medicine@jenksps.org

Last Name:_____ **First Name:**_____ **Age:**____ **Date of Birth:**____/_____/20___

Grade (2026-2027): _____ **Student ID#:**_____ **Sex**:_____ **Activity**:_____ **Date of Exam:** _____/_____/20___

MEDICAL HISTORY INFORMATION

List any past and current medical conditions (asthma, diabetes, anemia, etc.). _____

Have you ever had surgery? If yes, list all past surgical procedures. _____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional). _____

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

Patient Health Questionnaire Version 4 (PHQ-4) *Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)*

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	**0**	**1**	**2**	**3**
Not being able to stop or control worrying	**0**	**1**	**2**	**3**
Little or no interest in doing things	**0**	**1**	**2**	**3**
Feeling down, depressed, or hopeless	**0**	**1**	**2**	**3**

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL MEDICAL HISTORY QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	**YES**	**NO**
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	**YES**	**NO**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest of skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography?		
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		

HEART QUESTIONS ABOUT YOUR FAMILY	**UNSURE**	**YES**	**NO**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?			
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)?			
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?			

BONE AND JOINT QUESTIONS	**YES**	**NO**
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or a game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		

MEDICAL QUESTIONS	**YES**	**NO**
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?		
20. Have you had a concussion or a head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been able to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or someone in your family have sickle cell trait or disease **UNSURE**		
24. Have you ever had, or do you have any problems with your eyes or vision?		
25. Do you worry about your weight?		
26. Are you trying to or has someone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		

MENSTRUAL QUESTIONS	**N/A**	**YES**	**NO**
29. Have you ever had a menstrual period?			
30. How old were you when you had your first menstrual period?			
31. When was your most recent menstrual period?			
32. How many periods have you had in the past 12 months?			

Explain "Yes" answers here:

_____

_____

_____

_____

If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given to said student by any physician, athletic trainer, nurse or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student.
I (we) hereby state, to the best of my (our) knowledge, my (our) answers to above questions are complete and correct.

Signature of athlete: _____ **Date:** _____/_____/_____

Signature of parent or guardian: _____ **Date:** _____/_____/_____

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Last Name:_____ **First Name:**_____ **Age:**____ **Date of Birth:**____/_____/20___

Grade (2026-2027): _____ **Student ID#** _____ **Sex**:_____ **Activity**:_____ **Date of Exam:** _____/_____/20___

PHYSICAL EXAMINATION

Height: **Weight:** **BP:** **/** **Pulse:** **Vision: R 20/** **20/** **Corrected:** **Y** **N**

MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance ● Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat ● Pupils equal ● Hearing		
Lymph nodes		
Heart ● Murmurs (auscultation standing, auscultation supine, and +/- Valsalva maneuver)		
Lungs		
Abdomen		
Skin ● Herpes simplex virus (HSV), lesions of methicillin-resistant Staphylococcus aureus (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional ● Double-leg squat test, single leg squat test, and box drop or step drop test		

_____ **Medically eligible for all sports without restriction**

_____ **Medically eligible for all sports with recommendations for further evaluation or treatment of:**_____

_____ **Medically eligible for certain sports:**_____

_____ **Not medically eligible pending further evaluation for:**_____

_____ **Not medically eligible for any sports**

Recommendations:_____
_____
_____
_____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can practice in the sports(s) as outlined on this form. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care provider (print or type): _____ **Date:** _____/_____/_____

Address: _____ **Phone:** _____

Signature of health care professional: _____