Black Hills Youth Football and Cheer League-
P.O. Box 999
Box Elder, SD 57719
Email: Bhyfl.football.cheer@gmail.com
Phone: 605-791-3381

Pre-participation Physical Form Date of Exam: ____/____/____

Name:_____ Sex: □ M □F Age:_____

Date of Birth: ___/___/___ Grade fall 2022 : _____

Address: _____ Phone#:_____

Personal Physician: _____

Explain YES Answers below	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	□	□
2. Do you have any ongoing medical conditions?	□	□
3. Do you have any allergies to medicine, food or insect stings? Pls list	□	□
4. Have you ever had a headache, passed out or nearly passed out during or after exercise?	□	□
5. Does your heart race or skip beats during exercise?	□	□
6. Have you ever had discomfort, pain or pressure in your chest during exercise?	□	□
7. Has a doctor ever told you that you have asthma or allergies?	□	□
8. Do you cough, wheeze or have difficulty breathing during or after exercise?	□	□
9. Have you had infectious Mononucleosis (mono) within the last month?	□	□
10. Have you ever had a head injury or concussion?	□	□
11. Have you been hit in the head and been confused or lost your memory?	□	□
12. Have you ever had a seizure?	□	□
13. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	□	□
14. Have you ever been unable to move your arms or legs after being hit or falling?	□	□
15. When exercising in the heat, do you have severe cramps or became ill?	□	□
	□	□

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For the following questions, if yes, please indicate body part on chart below:

16. Have you ever had an injury, like a sprain, muscle or ligament tear, tendonitis that caused you to miss a practice or game?

17. Have you broken or fractured bones or dislocated joints?

18. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery injections, rehabilitation, physical therapy, a brace, a cast or crutches?

19. Have you ever had a stress fracture?

Head	Neck	Shoulder	Upper Arm	Elbow	Forearm
Hand/Fingers		Chest	Upper back	Hip	Thigh
Knee		Calf/Shin	Ankle	Foot/Toes	

Medical	**Normal**	**Skipped**	**Abnormal Findings**	**Initials**
Appearance	□	□		
Eyes/Ears/Nose/Throat	□	□		
Lymph Nodes	□	□		
Heart	□	□		
Pulses	□	□		
Lungs	□	□		
Abdomen	□	□		
Skin	□	□		
Genitalia	□	□		
	□	□		
Musculoskeletal	□	□		
Neck	□	□		
Back	□	□		
Shoulder/Arm	□	□		
Elbow/Forearm	□	□		
Wrist/Hand	□	□		
Hip/Thigh	□	□		
Knee	□	□		
Leg/Ankle	□	□		
Foot	□	□		

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Name:_____ Date of Birth: _____

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

Have you traveled anywhere within the last 60 days? If Yes, Where?

_____

Have you been in contact with anyone that may have the COVID-19? _____

Have you been diagnosed with COVID within the last month? _____

Has the patient had any of the following symptoms:

□ Cough □ Fever □Sore throat □ Shortness of breath

☐ Cleared without restriction

□ Cleared with recommendations for further evaluation or treatment
for:_____

□ Not cleared for: □ All Sports, □ Certain sports:_____
Reason:_____

Recommendations:

_____
_____
_____
_____
_____
_____

Allergies:_____
_____

Name of Physician:_____ Date:_____

Address:_____ Phone:_____

Signature of Physician:_____

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