

Last w/c 6/17/21

ALABAMA HIGH SCHOOL ATHLETIC ASSOCIATION

Preparticipation Physical Evaluation Form
Revised 2018

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History
Name Abigail J. Franks Sex F Age 13 Date 8-23-2021
Address 200 Town Madison Blvd, Apt 42012 Madison, AL Date of birth 5-28-2008
School Discovery Middle School Grade 8 Phone 706-284-7897 Sport rowing

Explain "Yes" answers below:	Yes	No
1. Has a doctor ever restricted/denied your participation in sports?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Have you ever been hospitalized or spent a night in a hospital?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have ever had surgery?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Do you have any ongoing medical conditions (like Diabetes or Asthma)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Are you presently taking any medications or pills (prescription or over-the-counter)?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Do you have any allergies (medicine, pollens, foods, bees or other stinging insects)?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you ever had chest pain or discomfort in your chest during or after exercise?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Do you tire more quickly than your friends during exercise?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you ever had high blood pressure?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you ever been told that you have a heart murmur, high cholesterol, or heart infection?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Has anyone in your family died of heart problems or a sudden death before age 50?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Does anyone in your family have a heart condition?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Has a doctor ever ordered a test on your heart (EKG, echocardiogram)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Do you have any skin problems (itching, rashes, staph, MRSA, acne)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Have you ever had a head injury or concussion?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Have you ever been knocked out or unconscious?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you ever had a seizure?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you ever had a stinger, burner, pinched nerve, or loss of feeling or weakness in your arms or legs?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Have you ever had heat or muscle cramps?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you ever been dizzy or passed out in the heat?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Do you have trouble breathing or do you cough during or after activity?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Do you take any medications for asthma (for instance, inhalers)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
11. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
12. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Do you wear glasses or contacts or protective eye wear?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
13. Have you had any other medical problems (infectious mononucleosis, diabetes, infectious diseases, etc.)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
14. Have you had a medical problem or injury since your last evaluation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
15. Have you ever been told you have sickle cell trait?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Has anyone in your family had sickle cell disease or sickle cell trait?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
16. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/> Head <input type="checkbox"/> Back <input type="checkbox"/> Shoulder <input type="checkbox"/> Forearm <input type="checkbox"/> Hand <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Ankle		
<input type="checkbox"/> Neck <input type="checkbox"/> Chest <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Finger <input type="checkbox"/> Thigh <input type="checkbox"/> Shin <input type="checkbox"/> Foot		
17. When was your first menstrual period? <u>12/2020</u>		
When was your last menstrual period? <u>8/2021</u>		
What was the longest time between your periods last year? <u>28 days</u>		
Explain "Yes" answers: <u>- over the counter allergy med., Lexapro 10 mg at bedtime</u> <u>- diagnosed w/ mild concussion after playground fall</u> <u>when 7 yrs old</u>		

muscle

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.

Signature of athlete _____ Date 8-23-2021

Signature of parent/guardian Robert H. Franks

DUPLICATE AS NEEDED

FORM 5

Preparticipation Physical Evaluation

Abigail J. Franks
Student's name

Rule 1, Sec. 14 — In order for a student to be eligible for interscholastic athletics, there must be on file in the Superintendent's or Principal's office a current physician's statement certifying that the student has passed a physical exam, and that in the opinion of the examining physician (M.D. or D.O.) the student is fully able to participate in interscholastic athletics (Grades 7-12). The AHSAA Physicians Certificate (Form 5 Rev. 2018) must be used. A physical exam will satisfy the requirement for one calendar year through the end of the month from the date of the exam. For example, a physical given on May 5, 2021, will satisfy the requirement through May 31, 2022.

Physical Examination

		Height <u>59</u> Weight <u>131</u> BP <u>115/109</u> Pulse <u>79</u>	Revised 2018	
		Vision R 20/ <u>20</u> L 20/ <u>20</u> Corrected: Y <input checked="" type="checkbox"/> N <input type="checkbox"/>		
COMPLETE	LIMITED	Normal	Abnormal Findings	
		Cardiovascular	<input checked="" type="checkbox"/>	
		Pulses	<input checked="" type="checkbox"/>	
		Heart	<input checked="" type="checkbox"/>	
		Lungs	<input checked="" type="checkbox"/>	
			Skin	<input checked="" type="checkbox"/>
			E.N.T.	<input checked="" type="checkbox"/>
			Abdominal	<input checked="" type="checkbox"/>
			Genitalia (males)	
			Musculoskeletal	
			Neck	<input checked="" type="checkbox"/>
			Shoulder	<input checked="" type="checkbox"/>
			Elbow	<input checked="" type="checkbox"/>
			Wrist	<input checked="" type="checkbox"/>
			Hand	<input checked="" type="checkbox"/>
		Back	<input checked="" type="checkbox"/>	
		Knee	<input checked="" type="checkbox"/>	
		Ankle	<input checked="" type="checkbox"/>	
		Foot	<input checked="" type="checkbox"/>	
		Other		

Clearance:

- A. Cleared
- B. Cleared after completing evaluation/rehabilitation for: _____
- C. Not cleared for:
 - Collision
 - Contact
 - Noncontact

Due to: _____

Recommendation: _____

Name of physician Dr. Debbie Benoit Harris Date 8/26/21
 Address 411 Towne Park Blvd. Phone 706.854.2500
 Signature of physician [Signature] M.D. or D.O.

(Form must be signed and dated by the attending physician.)