

ALABAMA HIGH SCHOOL ATHLETIC ASSOCIATION

Preparticipation Physical Evaluation Form
Revised 2018

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History

Name Morgan Nichols Sex F Age 15 Date 25 Jul 2021
 Address 222 Timber Creek Drive Date of birth 13 Mar 2006
 School Spunkman High School Grade 10 Phone 256-619-3439
 Sport Flag Football

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? 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 type="checkbox"/>	<input checked="" type="checkbox"/>
5. Do you have any allergies (medicine, pollens, foods, bees or other stinging insects)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Have you ever passed out during or after exercise? Have you ever been dizzy during or after exercise? Have you ever had chest pain or discomfort in your chest during or after exercise? Do you tire more quickly than your friends during exercise? Have you ever had high blood pressure? Have you ever been told that you have a heart murmur, high cholesterol, or heart infection? Have you ever had racing of your heart or skipped heartbeats? Has anyone in your family died of heart problems or a sudden death before age 50? Does anyone in your family have a heart condition? 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? Have you ever been knocked out or unconscious? Have you ever had a seizure? 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? Have you ever been dizzy or passed out in the heat?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
10. Do you have trouble breathing or do you cough during or after activity? 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? 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? 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"/> 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	<input type="checkbox"/>	<input checked="" type="checkbox"/>
17. When was your first menstrual period? <u>20 FEB 2018</u> When was your last menstrual period? <u>17 Jul 2021</u> What was the longest time between your periods last year?		
Explain "Yes" answers: <u>9. San Antonio - USAF BMT Graduation (2017)</u> <u>12. Glasses/contacts</u>		

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

Signature of athlete Morgan Nichols Date 7-26-21
 Signature of parent/guardian _____

DUPLICATE AS NEEDED

FORM 5

Preparticipation Physical Evaluation

Morgan Nichols
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 (Grade s 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, 2018, will satisfy the requirement through May 31, 2019.

Physical Examination

COMPLETE	LIMITED	Height <u>68 1/4</u> Weight <u>126</u> BP <u>116/72</u> Pulse <u>70</u>			
		Vision R 20 / ___ L 20 / ___ Corrected: <u>(Y)</u> N			
			Normal	Abnormal Findings	
		Cardiovascular	<input checked="" type="checkbox"/>		
		Pulses	<input checked="" type="checkbox"/>		
		Heart	<input checked="" type="checkbox"/>		
	COMPLETE	COMPLETE	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 ___ Strenuous ___ Moderately strenuous ___ Nonstrenuous

Due to: _____

Recommendation: _____

Name of physician Elizabeth Bryant MD Date 7/26/21
 Address 21 Hughes Rd Suite 2 Marietta GA Phone 772-2037
 Signature of physician E. Bryant MD 35752 M.D. or D.O.

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