

ALABAMA HIGH SCHOOL ATHLETIC ASSOCIATION

Preparticipation Physical Evaluation Form

Revised 2018

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History

Name Miranda Beauchamp Sex F Age 16
 Address 218 Curtis Dr SE Hsv, AL 35803
 School ALCA Grade 11

Date 7-6-21
 Date of birth 3/24/05
 Phone 256-648-4541
 Sport Rowing

Explain "Yes" answers below:

Question	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 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? 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 checked="" type="checkbox"/>	<input 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 type="checkbox"/>	<input checked="" 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 checked="" type="checkbox"/>	<input type="checkbox"/>
12. Have you had any problems with your eyes or vision? Do you wear glasses or contacts or protective eye wear?	<input type="checkbox"/>	<input checked="" 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 checked="" 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 checked="" type="checkbox"/>	<input type="checkbox"/>
17. When was your first menstrual period? <u>13 yrs old</u> When was your last menstrual period? <u>mid-June 2021</u> What was the longest time between your periods last year? <u>3-4 weeks</u>		

Explain "Yes" answers:

(H) Vitamins, 201off, omega-3, L-theanine, probiotic (S) seasonal lactose intolerant
 (C) Maternal grandmother - CAD (+) Acid (H) retainers (braces)
 (B) dislocated shoulder in 8th grade, went untreated that year, received treatment and doing better. Receives regular chiropractor adj. as well.

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

Signature of athlete Miranda Beauchamp Date 7/5/21
 Signature of parent/guardian Eugene Beauchamp

DUPLICATE AS NEEDED

FORM 5

Preparticipation Physical Evaluation

Miranda Beauchamp
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

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		Height <u>63 1/2"</u>	Weight <u>145</u>	BP <u>90/50</u>	Pulse <u>80</u>
		Vision R <u>20/16</u> L <u>20/20</u> Corrected: Y <input checked="" type="checkbox"/>			
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				
COMPLETE	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 Scott Field MD Date 7/6/21

Address 1106 Glenridge Dr. Hudson, AL 35801 Phone 881-2355

Signature of physician Scott Field MD, M.D. or D.O.