

ALABAMA HIGH SCHOOL ATHLETIC ASSOCIATION

Preparticipation Physical Evaluation Form

History

Name Santiago Casillas Sex M Age 17 Date Aug/25/21  
 Address 68 Summerlyn way SE Date of birth July/9/04 Phone 2566799742  
 School Huntsville High Grade 12 Sport Rowing

Explain "Yes" answers below:	Yes	No
1. Has a doctor ever restricted/denied your participation in sports?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized or spent a night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>
Have ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have any ongoing medical conditions (like Diabetes or Asthma)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you presently taking any medications or pills (prescription or over-the-counter)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any allergies (medicine, pollens, foods, bees or other stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had chest pain or discomfort in your chest during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Do you tire more quickly than your friends during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been told that you have a heart murmur, high cholesterol, or heart infection?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone in your family died of heart problems or a sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>
Does anyone in your family have a heart condition?	<input type="checkbox"/>	<input type="checkbox"/>
Has a doctor ever ordered a test on your heart (EKG, echocardiogram)?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have any skin problems (itching, rashes, staph, MRSA, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been knocked out or unconscious?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a seizure?	<input type="checkbox"/>	<input 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 type="checkbox"/>
9. Have you ever had heat or muscle cramps?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been dizzy or passed out in the heat?	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have trouble breathing or do you cough during or after activity?	<input type="checkbox"/>	<input type="checkbox"/>
Do you take any medications for asthma (for instance, inhalers)?	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear glasses or contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you had any other medical problems (infectious mononucleosis, diabetes, infectious diseases, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you had a medical problem or injury since your last evaluation?	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you ever been told you have sickle cell trait?	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone in your family had sickle cell disease or sickle cell trait?	<input type="checkbox"/>	<input 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 type="checkbox"/>
<input type="checkbox"/> Head <input type="checkbox"/> Back <input type="checkbox"/> Shoulder <input checked="" 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		
<i>L forearm break - 2008</i>		
17. When was your first menstrual period? _____		
When was your last menstrual period? _____		
What was the longest time between your periods last year? _____		
Explain "Yes" answers:		
_____		
_____		
_____		

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

Signature of athlete *Santiago Casillas* Date Aug/25/21  
 Signature of parent/guardian *[Signature]*

DUPLICATE AS NEEDED

# Preparticipation Physical Evaluation

**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) 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, 2015, will satisfy the requirement through May 31, 2016.

## Physical Examination

LIMITED	Height <u>5ft 7in</u> Weight <u>177 lbs</u> BP <u>126 / 75</u> Pulse <u>79</u>		
	Vision R 20 / <u>20</u> L 20 / <u>20</u> Corrected: Y <u>(N)</u>		
		Normal	Abnormal Findings
	Cardiovascular	↓	
	Pulses		
	Heart		
	Lungs		
	Skin		
	E.N.T.		
	Abdominal		
	Genitalia (males)		
	Musculoskeletal		
	Neck		
	Shoulder		
	Elbow		
	Wrist		
	Hand		
	Back		
	Knee		
Ankle			
Foot			
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 Joel Edwall MD Date 8/25/21

Address 301 Governors Dr SW, Huntsville AL, 35811 Phone \_\_\_\_\_

Signature of physician [Signature]  M.D. or D.O.