



JUST UNDERSTAND MY POTENTIAL INC.
Pre-Participation Medical Evaluation

Name:	DOB:	
Past Medical History:		
Current Health Issues:		
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/> Allergies: Medications: Food: Other:	
<input type="checkbox"/>	<input type="checkbox"/> Asthma	
<input type="checkbox"/>	<input type="checkbox"/> Other:	
Current Medications (Include name, dose and times of administration):		
<input type="checkbox"/> May administer ibuprofen 10 mg/kg orally every 6 hours as needed for pain/fever <input type="checkbox"/> May administer acetaminophen 15 mg/kg orally every 4 hours as needed for pain/fever <input type="checkbox"/> May administer diphenhydramine 25-50 mg orally every 4-6 hours as needed for rash/itching/allergy		
Physical Examination		
Date of Examination:		
Height: _____ inches or cm	Weight: _____ lbs or kg BP: _____	
<input type="checkbox"/> The entire examination was normal (may skip below)		
<input type="checkbox"/> General:	<input type="checkbox"/> Lungs:	
<input type="checkbox"/> Skin:	<input type="checkbox"/> Heart:	
<input type="checkbox"/> HEENT:	<input type="checkbox"/> Abdomen:	
<input type="checkbox"/> Dental:	<input type="checkbox"/> Genitalia:	
<input type="checkbox"/> Extremities:	<input type="checkbox"/> Neurologic:	
<input type="checkbox"/> Other:		
The participant has the following issues which may affect his/her participation:		
<input type="checkbox"/> Decreased vision/hearing	<input type="checkbox"/> Other:	
<input type="checkbox"/> Fine/gross motor deficit	Comments/recommendations:	
<input type="checkbox"/> Behavioral issues		
Immunizations are complete: <input type="checkbox"/> Yes <input type="checkbox"/> No Date of last tetanus vaccine: _____		
Copy of Immunization Record Attached: <input type="checkbox"/> Yes		
May participate fully in outdoor program, including hiking/camping: <input type="checkbox"/> Yes <input type="checkbox"/> No		
If no, list restrictions:		
_____	_____	_____
Signature of examiner	Date	Telephone Number
_____	_____	
Print name of examiner	Address	

(Please attach additional information as needed for the health and safety of the participant)

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1-3-12