



Oxford Golden Bears
2026 Comprehensive Initial Pre-Participation
Physical Evaluation

SECTION 1: PERSONAL AND EMERGENCY INFORMATION

ATHLETE'S PERSONAL INFORMATION

Male / Female (Circle One)

Name: _____

Date of Birth ____/____/____ Age on Last Birthday: ____ Grade for 2026/2027 season: ____

Current Physical Address _____

Current Home Phone # _____ Parent/Guardian Current Cellular Phone # _____

EMERGENCY INFORMATION

Parent's/Guardian's Name _____ Relationship _____

Address _____ Emergency Contact Phone # _____

Secondary Emergency Contact Person's Name _____ Relationship _____

Address _____ Emergency Contact Phone # _____

Medical Insurance Carrier _____ Policy Number _____

Address _____ Phone # _____

Family Physician's Name _____, MD or DO (circle one)

Address _____ Phone # _____

Athlete's Allergies _____

Athlete's Health Condition(s) of which an Emergency Physician Should be Aware _____

Athlete's Prescription Medication(s) _____

SECTION 2: CERTIFICATION OF PARENT/GUARDIAN

The athlete's parent/guardian must complete all parts of this form.

I hereby give my consent for _____ born on _____

who turned ____ on his/her last birthday, a resident of (city/town) _____,

to participate in Practices, Scrimmages, and/or Contests and Games during the 2026/2027 season in the following sport (circle one):

- Flag football Rookie Tackle/Tackle football Flag Cheerleading Cheerleading for tackle football

Signature of Parent or Guardian _____



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SECTION 3: HEALTH HISTORY

Explain "Yes" answers at the bottom of this form. Circle questions you don't know the answers to.

	Yes	No
1. Has a doctor ever denied or restricted your participation in sport(s) for any reason?		
2. Do you have an ongoing medical condition (like asthma or diabetes)?		
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?		
4. Do you have allergies to medicines, pollens, foods, or stinging insects?		
5. Have you ever passed out or nearly passed out DURING exercise?		
6. Have you ever passed out or nearly passed out AFTER exercise?		
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?		
8. Does your heart race or skip beats during exercise?		
9. Has a doctor ever told you that you have (check all that apply): <input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> Heart infection		
10. Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram)		
11. Has anyone in your family died for no apparent reason?		
12. Does anyone in your family have a heart problem?		
13. Has any family member or relative been disabled from heart disease or died of heart problems or sudden death before age 50?		
14. Does anyone in your family have Marfan syndrome?		
15. Have you ever spent the night in a hospital?		
16. Have you ever had surgery?		
17. Have you ever had an injury, like a sprain, muscle, or ligament tear, or tendonitis, which caused you to miss a Practice or Contest? If yes, circle affected area below:		
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:		
19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:		
Head Neck Shoulder Upper arm Elbow Forearm Hand/Fingers Chest		
20. Have you ever had a stress fracture?		
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?		
22. Do you regularly use a brace or assistive device?		

	Yes	No
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23. Has a doctor ever told you that you have asthma or allergies?		
24. Do you cough, wheeze, or have difficulty breathing DURING or AFTER exercise?		
25. Is there anyone in your family who has asthma?		
26. Have you ever used an inhaler or taken asthma medicine?		
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?		
28. Have you had infectious mononucleosis (mono) within the last month?		
29. Do you have any rashes, pressure sores, or other skin problems?		
30. Have you ever had a herpes skin infection?		
CONCUSSION OR TRAUMATIC BRAIN INJURY		
31. Have you ever had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury?		
32. Have you been hit in the head and been confused or lost your memory?		
33. Do you experience dizziness and/or headaches with exercise?		
34. Have you ever had a seizure?		
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
36. Have you ever been unable to move your arms or legs after being hit or falling?		
37. When exercising in the heat, do you have severe muscle cramps or become ill?		
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?		
39. Have you had any problems with your eyes or vision?		
40. Do you wear glasses or contact lenses?		
41. Do you wear protective eyewear, such as goggles or a face shield?		
42. Are you unhappy with your weight?		
43. Are you trying to gain or lose weight?		
44. Has anyone recommended you change your weight or eating habits?		
45. Do you limit or carefully control what you eat?		
46. Do you have any concerns that you would like to discuss with a doctor?		



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	Yes	No
FEMALES ONLY		
47. Have you ever had a menstrual period?		
48. How old were you when you had your first menstrual period?		
49. How many periods have you had in the last 12 months?		
50. Are you pregnant?		

Explain "Yes" answers here:

#'s	Explain "Yes" answers here:

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Athlete's Signature _____ Date ____/____/____

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Athlete's/Guardian's Signature _____ Date ____/____/____



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SECTION 4: COMPREHENSIVE INITIAL PRE-PARTICIPATION PHYSICAL EVALUATION AND CERTIFICATION OF AUTHORIZED MEDICAL EXAMINER

Must be completed and signed by the Authorized Medical Examiner (AME) performing the herein named athlete's comprehensive initial pre-participation physical evaluation (CIPPE) and turned into the Oxford Golden Bears Football and Cheerleading Organization.

Athlete's Name _____ Age _____ Grade _____

Sport _____ Height _____ Weight _____ % Body Fat (optional) _____

Brachial Artery BP _____/_____/_____ (_____/_____, _____/_____) RP _____

If either the brachial artery blood pressure (BP) or resting pulse (RP) is above the following levels, further evaluation by the athlete's primary care physician is recommended.

Vision: R 20/____ L 20/____ Corrected: YES NO (circle one) Pupils: Equal _____ Unequal _____

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
Eyes/Ears/Nose/Throat		
Hearing		
Lymph Nodes		
Cardiovascular		<ul style="list-style-type: none"><input type="checkbox"/> Heart murmur<input type="checkbox"/> Femoral pulses to exclude aortic coarctation<input type="checkbox"/> Physical stigmata of Marfan syndrome
Cardiopulmonary		
Lungs		
Abdomen		
Genitourinary (males only)		
Neurological		
Skin		



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MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		

I hereby certify that I have reviewed the HEALTH HISTORY, performed a comprehensive initial pre-participation physical evaluation of the herein named athlete, and, on the basis of such evaluation and the athlete's HEALTH HISTORY, certify that, except as specified below, the athlete is physically fit to participate in Practices, Scrimmages, and/or Contests and Games in the sport consented to by the athlete's parent/guardian in Section 2 of the

Comprehensive Initial Pre-Participation Physical Evaluation form:

- CLEARED
- CLEARED, with recommendation(s) for further evaluation or treatment for: _____
- NOT CLEARED for the following types of sports (please check those that apply):
- COLLISION
- CONTACT
- NON-CONTACT
- STRENUOUS
- MODERATELY STRENUOUS
- NON-STRENUOUS

Due to _____

Recommendation(s)/Referral(s) _____

AME's Name (print/type) _____ License # _____

Address _____ Phone _____

AME's Signature _____ MD, DO, PAC, CRNP, or SNP (circle one)

Date of CIPPE __/__/