PRE-PARTICIPATION PHYSICAL EVALUATION

To whom it may concern,

Attached is the 2026 Marching Thunder pre-participation physical examination form. Please use this form to complete the student's pre-participation exam. This student is participating in marching band at the collegiate level.

Marching band at the collegiate level may include:

- Lower extremity demands similar to basketball or soccer
- Carrying instruments up to 50lbs, while marching/jazz running >200 steps/minute
- Extreme heat: ground temperature can exceed 160° F (i.e. synthetic turf)
- Rehearsing for several hours at a time, outdoors
- Dancing/Marching on a variety of surfaces including grass, dirt, asphalt
- Highly repetitive activities => risk of overuse and repetitive strain injuries

Prior to participation, we feel it is important that students meet with their Primary Care Physician or other medical professional to address the following:

- Complete medical exam
- Complete musculoskeletal exam
- Hearing / Vision exam
- Mental health, including anxiety and depression

Thank you for your careful consideration of this student's participation in Marshall University's Marching Thunder!

Sincerely,
Emily Lewis, MS, LAT, ATC, CSCS, NASM-CPT, PES
Marshall University Center for Wellness in the Arts: Athletic Trainer
fankhanel1@marshall.edu

PRE-PARTICIPATION PHYSICAL EVALUATION

Marching Thunder Participants (Please READ!): The instructions below provide important information to complete this form correctly. If you have any questions, please reach out to Emily at fankhanel1@marshall.edu.

Name (print): _____

Date of Birth: _____ Email: _____@marshall.edu

Section: _____ Year in College: _____

Part 1: Health History

- This portion of the form is to be completed by the participant (if 18 years or older) OR by their parent/guardian (if under 18y/o).
- **If you answer "Yes" to any of the questions below**, please provide further explanation at the bottom of this form.
    - For example, if you say "yes" to having an allergy, you must specify what your allergy is and how severe, or if you say "yes" to passing out, you must explain the situation further to the best of your ability. Etc.
- Circle the questions you do not have an answer for, but please try to fill out the form as completely as possible to the best of your ability.

	Y	N		Y	N
1. Has a doctor ever denied or restricted your participation in extracurricular(s) for any medical reason?			10. Has your doctor ever ordered a test for your heart (ECG, etc.)?		
2. Do you have any ongoing medical conditions (e.g. asthmas, diabetes, POTS, heart condition, etc.)			11. Any personal or family history of genetic conditions (e.g. Marfan's syndrome, sickle cell anemia, etc.)?		
3. Are you currently taking any medications?			12. Any family history of heart conditions or complications?		
4. Do you have any allergies to medication, pollens, foods, or stinging insects?			13. Any family history of sudden death before age 50?		
5. Have you ever passed out or nearly passed our DURING physical activity?			14. Have you ever had surgery? If yes, please specify.		
6. Has your doctor ever told you that you have any of the following conditions: High Blood Pressure, Heart Murmur, High Cholesterol, or Heart infection			15. Any history of acute, sudden, or chronic musculoskeletal injuries (e.g. strain, sprain, facture, tendinitis, dislocation, stress fracture, etc.)? If so, please specify.		
7. Have you ever passed out or nearly passed out AFTER physical activity?			16. Any history of repeat fractures or dislocations?		
8. Does your heart race or skip beats during physical activity?			17. Do you regularly use a brace or assistive device? If yes, please specify.		
9. Have you ever had discomfort, pain or pressure in your chest during physical activity?			18. Any history of seizures?		

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19. Do you take any medications for seizures?			31. Have you ever had a concussion or traumatic brain injury?		
20. Do you wear glasses or contact lenses?			32. Have you ever experienced confusion, memory loss, and/or passed out after being hit in the head?		
21. Do you have any issues with your eyes/vision?			33. Do you experience dizzimess and/or headaches with exercise?		
22. Do you wear protective eyewear, such as goggles or a face shield?			34. Do you suspect that you may have experienced a concussion within the past year, even without an official diagnosis? If yes, please specify to the best of your ability.		
23. Do you have allergies? If yes, please specify allergen(s) and severity.			35. Have you ever experienced numbness, tingling, or weakness in your arms or legs after being hit or falling?		
24. Do you often cough, wheeze, or have significant difficulty breathing during or after physical activity?			36. Have you ever been unable to move your arms or legs after being hit or falling?		
25. Do you have asthma?			37. Have you ever had a concussion or traumatic brain injury?		
26. Have you ever used an inhaler or taken asthmas medication?			38. Have you ever experienced confusion, memory loss, and/or passed out after being hit in the head?		
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?			39. When exercising in the heat, do you have severe muscle cramps or become ill?		
28. Have you had infectious mononucleosis (mono) within the last month?			40. Do you or anyone in your family have sickle cell trait or sickle cell disease?		
29. Do you have any rashes, pressure, sores, or other skin problems?			41. Do you have any history of eating disorders?		
30. Have you ever had a herpes skin infection?			42. Do you have any concerns that you would like to discuss with a doctor?		

*Place your explanations into the provided box <u>below.</u> **Please list the question number next to your explanation.** Thank you!

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

Student signature: _____

Date: _____/_____/_____

Parent Signature: _____

Date: _____/_____/_____

Pre-Participation Physical Evaluation

Participant's Name: _____

Sport/Activity: _____

DOB: _____ Age: _____ Height: _____ Weight: _____

Blood Pressure: _____

If either the brachial artery blood pressure (BP) or resting pulse (RP) is above the following levels, further evaluation by the participant's primary care physician is recommended.
Age 10-12: BP: >126/82, RP: >104; **Age 13-15:** BP: >136/86, RP >100; **Age 16-25:** BP: >142/92, RP >96.

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		
Cardiopulmonary		
Lungs		
Abdomin		

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Genitourinary (males only)		
Neurological		
Skin		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		

CLEARED with recommendation(s) for further evaluation or treatment for:

_____

NOT CLEARED due to:_____

Recommendation(s)/Referral(s):_____

Examiner's Name (print): _____

Signature of Examiner: _____

License #_____ *(circle one)* MD, DO, PAC, CRNP, or SNP

I hereby certify that I have reviewed the Health History form, performed a comprehensive initial pre-participation physical evaluation of the herein named student, and, on the basis of such evaluation and the student's Health History, certify that, except as specified below, the student is physically fit to participate in practices, inter-school Practices, scrimmages, and/or contests in the activity/sport(s) consented to by the participant or their parent/guardian above.

Physician's Signature: _____

Date: _____/_____/2026