Sports Physical Form

Name: _____
Gender: M ☐ F ☐ Date of Birth: ___/___/___
Father's Name: _____
Daytime phone:_____ Mobile_____
Mother's Name: _____
Daytime phone:_____ Mobile_____

Street address: _____
City: _____ State: _____ Zip Code: _____

Alternate Emergency Contact Person: _____
Relationship to player: _____

Please indicate MEDICAL ALERTS such as allergic reactions, contact lenses, etc.:
_____

Medical History:

Athletes and parents:
This health record is a critical element in the determination of an athlete's risk of injury in sports.
Please take the time to read and answer all questions before seeing a physician for the athlete's physical examination. Please check appropriate answer.

1. Has anyone in the athlete's family (grandparents, mother/father, brother/sister, aunt/uncle) died suddenly before age 50?
YES☐ NO☐ Don't Know☐ If Yes, please detail:_____

2. Does the athlete have a history of concussion (getting knocked out)? YES☐ NO☐ Don't Know☐
If Yes, approximate date of last concussion (month/year) _____/_____
If Yes, how many concussions has the athlete suffered? _____

3. Has the athlete ever stopped exercising because of dizziness or passed out during exercise? YES☐ NO☐ Don't Know☐

4. Does the athlete have asthma (wheezing), hay fever, or coughing spells after exercise? YES☐ NO☐ Don't Know☐

5. Has the athlete ever had a broken bone, had to wear a cast, or had an injury to any joint? YES☐ NO☐ Don't Know☐

6. Has the athlete ever suffered a heat-related illness (heat stroke)? YES☐ NO☐ Don't Know☐

7. Does the athlete have a chronic illness or see a doctor regularly for any particular problem? YES☐ NO☐ Don't Know☐

8. Does the athlete take any medication(s)? YES☐ NO☐ Don't Know☐
If yes, please list:_____
9. Is the athlete allergic to any medications , food or insect stings? YES☐ NO☐ Don't Know☐
If yes, please list:_____

10. Does the athlete have only one of any paired organs? (Eyes, ears, kidneys, testicles, ovaries) YES☐ NO☐ Don't Know☐

11. Has the athlete had an injury in the last year that caused the athlete to miss 3 or more consecutive days of practice or competition? YES☐ NO☐ Don't Know☐

12. Has the athlete had surgery or been hospitalized in the past year? YES☐ NO☐ Don't Know☐

13. Has the athlete missed more than 5 consecutive days of participation in usual activities because of illness, or has the athlete had a medical illness diagnosed that has not been resolved in the past year? YES☐ NO☐ Don't Know☐

14. Are you, the athlete, worried about any problem or condition at this time? YES☐ NO☐ Don't Know☐

Please give details on any "YES" answer from the above health history.

Question #_____
Question #_____
Question #_____

The Physician Examination Is Required For Junior High and High School Only

PHYSICAL EXAM – TO BE COMPLETED BY PHYSICIAN

Height _____ Weight _____ Pulse _____ Blood Pressure _____

Normal Abnormal Findings Initials

1. Eyes
2. Ears, Nose, Throat
3. Mouth & Teeth
4. Neck
5. Cardiovascular
6. Chest & Lungs
7. Abdomen
8. Skin
9. Genitalia-Hernia (male)
10. Muscoskeletal: ROM, strength, etc.
    a. neck
    b. spine
    c. shoulders
    d. arms/ hands
    e. hips
    f. thighs
    g. knees
    h. ankles
    i. feet
11. Neuromuscular

Please Print/ Stamp

Physician's Name _____
Street Address _____
City, State, Zip Code _____
Telephone _____

I certify that I have examined this athlete and found him/her medically qualified to participate in sports. I also certify that I am a licensed medical physician, physician's assistant, or family nurse practitioner. (Doctor of Chiropractic Medicine is not satisfactory.)

Physician Signature _____ Date _____

PARTICIPATION RESTRICTIONS: _____