TO BE COMPLETED BY PARENT

Name_____ Sex_____ Age_____ Date of Birth _____

Grade_____ Sport(s) _____ _____ _____

Personal physician _____

Explain "Yes" answers below.	Yes	No
1. Have you ever been hospitalized?	☐	☐
Have you ever had surgery?	☐	☐
2. Are you presently taking any medications or pills?	☐	☐
3. Do you have any allergies (medicine, bees, or other stinging insects)?	☐	☐
4. Have you ever passed out during or after exercise?	☐	☐
Have you ever been dizzy during or after exercise?	☐	☐
Have you ever had chest pain during or after exercise?	☐	☐
Do you tire more quickly than your friends during exercise?	☐	☐
Have you ever had high blood pressure?	☐	☐
Have you ever been told that you have a heart murmur?	☐	☐
Have you ever had racing of your heart or skipped heartbeats?	☐	☐
Has anyone in your family died of heart problems or a sudden death before age 50?	☐	☐
5. Do you have any skin problems (itching, rashes, acne)?	☐	☐
6. Have you ever had a head injury?	☐	☐
Have you ever been knocked out or unconscious?	☐	☐
Have you ever had a seizure?	☐	☐
Have you ever had a stinger, burner, or pinched nerve?	☐	☐
7. Have you ever had heat or muscle cramps?	☐	☐
Have you ever been dizzy or passed out in the heat?	☐	☐
8. Do you have trouble breathing or do you cough during or after activity?	☐	☐
9. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)?	☐	☐
10. Have you had any problems with your eyes or vision?	☐	☐
Do you wear glasses or contacts or protective eye wear?	☐	☐
11. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints?	☐	☐
☐ Head ☐ Shoulder ☐ Thigh ☐ Neck ☐ Elbow ☐ Knee ☐ Chest ☐ Forearm ☐ Shin/calf ☐ Back ☐ Wrist ☐ Ankle ☐ Hip ☐ Hand ☐ Foot		
12. Have you had any other medical problems? (Infectious mononucleosis, diabetes, etc.)?	☐	☐
13. Have you had a medical problem or injury since your last evaluation?	☐	☐
14. When was your first menstrual period? _____ When was your last menstrual period? _____		
15. Do you have any organs missing?	☐	☐

Explain "Yes answers:_____

I give my permission for my student to have a sports physical and hereby state that, to the best of my knowledge, the answers to the above questions are correct. Students receiving a sports physical will receive a standard adolescent risk assessment. I understand that the American Academy of Pediatrics recommends a Comprehensive Physical or Well Child Exam every two years with a primary care provider to address issues which cannot be addressed in this sports physical.

Date _____

Signature of athlete_____

Signature of parent/guardian _____

TO BE COMPLETED BY PHYSICIAN

Physical Examination **Date of Physical:** _____

Student Name _____

Height_____ Weight_____ BP___/___ Pulse _____ Vision: R 20/ L 20/_____ Corrected: Y N Pupils _____

_____ Date of last DPT/Td_____ MMR #_____ Hep. B _____

	Normal	Abnormal Findings	Initials
Cardiopulmonary			
Pulses			
Heart			
Lungs			
Skin			
Abdominal			
Musculoskeletal			
Neck			
Shoulder			
Elbow			
Wrist			
Hand			
Back			
Knee			
Ankle			
Foot			
Other			

CLEARANCE

A. Cleared

B. Cleared after completing re-evaluation/rehabilitation for:

_____

C. Not cleared for ☐ Collision ☐ Contact ☐ Non-contact: ☐ Strenuous ☐ Moderately strenuous ☐ Non-strenuous

Due to _____

RECOMMENDATION:_____

_____

I hereby certify that I have examined above named student and that the student was found physically fit to engage in school athletics/activities (except as listed above).

Please Print or use stamp:

Name of Provider_____ Date _____

Address_____ Phone _____

_____

Signature of Provider _____

Title of Provider (please check one)_____MD ____DO ____PA ____NP