DIVISION OF STUDENT ENGAGEMENT AND SUCCESS

Sports Physical Form

This section of the form is to be completed by the student (who anticipates participation in sports) or parent (if student is a minor) prior to visiting the physician/nurse practitioner or physician assistant.

Name: _____ Gender: M___ F___ Date of Birth: ___/___/___
Father's Name: _____ Telephone Number: _____
Mother's Name: _____ Telephone Number: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Emergency Contact Person: _____ Relationship: _____ Telephone Number: _____
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 prior to visiting a physician for the athletic physical examination.

1. Has anyone in the athlete's family (grandparents, mother, father, brother, sister, or aunt) died suddenly before age 50?	YES	NO	Do Not Know
2. Has the athlete ever stopped exercising because of dizziness or passed out during exercise?	YES	NO	Do Not Know
3. Does the athlete have asthma (wheezing), hay fever, or coughing spells after exercise?	YES	NO	Do Not Know
4. Has the athlete ever had a broken bone, had to wear a cast, or had an injury to any joint?	YES	NO	Do Not Know
5. Does the athlete have a history of concussion (getting knocked out)?	YES	NO	Do Not Know
6. Has the athlete ever suffered a heat-related illness (heat stroke)?	YES	NO	Do Not Know
7. Does the athlete have a chronic illness or see a doctor regularly for any particular problem?	YES	NO	Do Not Know
8. Does the athlete take any medication(s)?	YES	NO	Do Not Know
9. Is the athlete allergic to any medications or bee stings?	YES	NO	Do Not Know
10. Does the athlete have only one of any paired organs? (Eyes, ears, kidneys, testicles, ovaries)	YES	NO	Do Not 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	Do Not Know
12. Has the athlete had surgery or been hospitalized in the past year?	YES	NO	Do Not 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	Do Not know
14. Are you, the athlete, worried about any problem or condition at this time?	YES	NO	Do Not Know

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

_____
_____
_____
_____
_____
_____
_____

PHYSICAL EXAM – This section is to be completed by a physician/nurse practitioner/physician assistant.

Height _____ Weight _____ Pulse _____ Blood Pressure _____

Vision: R 20/ L20/ Corrected Y or N

Review of Systems		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.	Musculoskeletal: ROM, strength, etc.					
a.	neck					
b.	spine					
c.	shoulders					
d.	arms/hands					
e.	hips					
f.	thighs					
g.	knees					
h.	ankles					
i.	feet					
11.	Neuromuscular					

PARTICIPATION RESTRICTIONS:

_____

_____

_____

_____

_____

_____

Please Print/ Stamp
Provider's Name _____
Street Address _____
City, State, Zip Code _____
Telephone Number_____

_____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 assistant, or family nurse practitioner (Doctor of Chiropractic Medicine is not acceptable).

Provider's Signature _____ Date _____