

ATHLETIC PHYSICAL FORM

Physician's Examination

Name _____ Age _____ Date of Birth ____/____/____

COMPLETE	LIMITED	Height _____ Weight _____ Blood Pressure _____ / _____ Pulse _____		
		Vision: Right 20/_____ Left 20/_____ Corrected: Y N Pupils _____		
			NORMAL	ABNORMAL FINDINGS
		Cardiopulmonary		
		Pulses		
		Heart		
		Lungs		
		Skin		
		Abdominal		
		Musculoskeletal		
		Neck		
		Shoulder		
		Elbow		
		Wrist		
		Hand		
		Back		
		Knee		
Ankle				
Foot				
Other				

CLEARANCE

A. CLEARED

B. CLEARANCE DEFERRED until completing evaluation/rehabilitation for:

C. NOT Cleared for: Collision
 Contact
 Non-contact
 Strenuous Moderately Strenuous Non-strenuous

Due to: _____

Recommendation: _____

Examining Physicians (Must be MD, DO, PA, or Nurse Practitioner) **MUST HAVE STAMP** and Date

Medical Personnel Signatruue and Stamp _____ Date _____

ATHLETIC PHYSICAL FORM

Medical History

Name _____ Age _____ Date of Birth _____ Sex _____

Grade Level _____ Sport (s) _____

Family Physician _____ Physician's Phone # _____

ANSWER EACH QUESTION. EXPLAIN "YES" ANSWERS IN SPACE BELOW.

		YES	NO
1.	Have you ever been hospitalized?.....		
	Have you ever had surgery?.....		
	Do you have a history of chronic illness for which you see a doctor regularly?.....		
	Have you experienced any unexplained weight loss?.....		
	Have you had a medical problem or injury since your last physical examination?.....		
2.	Are you presently taking any medication or pills?.....		
3.	Do you have any allergies (medication, bees or 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 you have a heart murmur?.....		
	Have you ever had your heart "race" or skip beats?.....		
	Has anyone in your family died of heart problems or suddenly before the age of 50?.....		
5.	Do you have any skin problems (itching, rashes or acne)?.....		
6.	Have you ever had a head injury and/or a concussion?.....		
	Have you ever been knocked out or unconscious?.....		
	Have you ever had a seizure?.....		
	Have you ever had a stinger or 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 cough or have trouble breathing during or after activity?.....		
	Do you have asthma?.....		
9.	Do you use any special equipment (pads, braces, neck rolls, mouth guards, eye guards etc)?.....		
10.	Have you had any trouble with your eyes or vision?.....		
	Do you wear glasses, contacts or protective eye wear?.....		
11.	Have you sprained/strained, dislocated, fractured, had repeated swelling or other injuries of any bones or joints?...		
12.	Do you have any other medical problem (infectious mononucleosis, diabetes etc)?.....		
13.	When was your last tetanus shot? _____		
	When was your last measles immunization? _____		
14.	When was your first menstrual period? _____		
	When was your last menstrual period? _____		
	What was the longest time between periods last year? _____		

Explanation of "YES" answers: _____

I hereby state that, to the best of my knowledge, the information given above is correct.

Parent/Guardian signature _____ Date _____