For Office Use Only:
Date Received: / /
Update Attendance: ☐ Yes
Initial:

SPORTS PHYSICAL FORM TO BE COMPLETED BY PARENT

Last Name , First Name Middle

/ / Birth Date ☐ Male ☐ Female

Home Address **(Please "NO" P.O. Box)**

City State Zip Code

( ) - Primary Phone ( ) - Secondary Phone

Student Lives With: ☐ Mother ☐ Father Other:

Father's Name ( ) - Phone ☐ Daytime phone ☐ Pager ☐ Cellular

Mother's Name ( ) - Phone ☐ Daytime phone ☐ Pager ☐ Cellular

Alternate Emergency Contact Person ( ) - Phone ☐ Daytime phone ☐ Pager ☐ Cellular

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.

1.	Has anyone in the athlete's family (grandparents, mother father, brother, sister, aunt, uncle) die suddenly before the age of 50?	☐ Yes	☐ No	☐ Don't Know
2.	Has the athlete ever stopped exercising because of dizziness or passed out during exercise?	☐ Yes	☐ No	☐ Don't Know
3.	Does the athlete have asthma (wheezing), hay fever, or coughing spells after exercising?	☐ Yes	☐ No	☐ Don't Know
4.	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
5.	Does the athlete have a history of concussions (getting knocked out)?	☐ 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
9.	Is the athlete allergic to any medications or bee stings?	☐ Yes	☐ No	☐ Don't Know
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?

PHYSICAL EXAM-TO BE COMPLETED BY PHYSICIAN

_____ , _____

Last Name First Name Middle

_____ / _____ / _____ ☐ Male ☐ Female

Birth Date

Height: Ft inches Weight: Lbs. Pulse: _____ Blood Pressure: _____

Vision:

Right: _____ / _____ uncorrected Right: _____ / _____ corrected

Left: _____ / _____ uncorrected Left: _____ / _____ corrected

		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.			
11.	a. Neck			
12.	b. Spine			
13.	c. Shoulders			
14.	d. Arms / Hands			
15.	e. Hips			
16.	f. Thighs			
17.	g. Knees			
18.	h. Ankles			
19.	i. Feet			
20.	Neuromuscular			

Please Print / Stamp

Physician's Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: ( ) -

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 or Chiropractic Medicine is not satisfactory.)

_____ / / _____

Physician Signature Date

PARTICIPATION RESTRICTIONS:

_____

_____