Athletic Physical Form

SCHOOL YEAR: _____ - _____

STUDENT INFORMATION

Last Name _____ First Name _____ MI _____ Student ID # _____

Street Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____ Email Address _____

☐ Male ☐ Female Date of Birth: _____ /_____ /_____ Grade entering: _____

Sports Played: _____

PHYSICAL EXAMINATION

Height _____ Weight _____

BP _____ Resting Pulse _____ Vision R 20/_____ L 20/_____ Corrected? ☐ Yes ☐ No

MEDICAL	NORMAL?		MUSCULOSKELETAL	NORMAL?	
Appearance	☐ Yes	☐ No	Neck	☐ Yes	☐ No
Eyes/ears/nose/throat	☐ Yes	☐ No	Back	☐ Yes	☐ No
Lymph nodes	☐ Yes	☐ No	Shoulder/Arm	☐ Yes	☐ No
Heart	☐ Yes	☐ No	Elbow/Forearm	☐ Yes	☐ No
Pulses	☐ Yes	☐ No	Wrist/Hand/Fingers	☐ Yes	☐ No
Lungs	☐ Yes	☐ No	Hip/Thigh	☐ Yes	☐ No
Abdomen	☐ Yes	☐ No	Knee	☐ Yes	☐ No
Genitourinary (males only)	☐ Yes	☐ No	Leg/Ankle	☐ Yes	☐ No
Skin	☐ Yes	☐ No	Foot/Toes	☐ Yes	☐ No
Neurologic	☐ Yes	☐ No	Functional	☐ Yes	☐ No

Explain any abnormal findings: _____

_____

Emergency medications required on-site: ☐ Inhaler ☐ Epinephrine ☐ Glucagon ☐ Other: _____

Comments: _____

I have reviewed the data above, reviewed the medical history form, and make the following recommendations for participation in athletics:

☐ CLEARED without restrictions

☐ CLEARED with following notation: _____

☐ Cleared AFTER documented further evaluation or treatment for: _____

☐ Cleared for LIMITED participation. *Reason:* _____ Until Date: _____

☐ NOT CLEARED for participation. *Reason:* _____

Physician's Name _____ Telephone _____

Street Address, City, State, Zip _____

Physician's Signature _____ Date _____

MEDICAL HISTORY

The sports physical exam is not a substitute for a thorough annual exam by a student's primary care physician.

GENERAL MEDICAL HISTORY	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2. Do you currently have an ongoing medical condition? If so, please identify: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections ☐ Other	☐	☐
3. Have you ever spent the night in the hospital?	☐	☐
4. Have you ever had surgery?	☐	☐
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?	☐	☐
6. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
7. Does your heart race or skip beats during exercise?	☐	☐
8. Has a doctor ever told you that you have (check all that apply): ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease ☐ Other:	☐	☐
9. Has a doctor ever ordered a test for your heart? (i.e., ECG/EKG, echocardiogram)	☐	☐
10. Do you get lightheaded or feel more short of breath than expected during exercise?	☐	☐
11. Have you ever had an unexplained seizure?	☐	☐
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
12. Has any family member or relative died of heart problems or had an unexpected sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?	☐	☐
13. Does anyone in your family have a heart problem?	☐	☐
14. Does anyone in your family have a pacemaker or implanted defibrillator?	☐	☐
15. Does anyone in your family have Marfan syndrome, cardiomyopathy, or Long Q-T?	☐	☐
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?	☐	☐
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis that caused you to miss a practice or game?	☐	☐
18. Have you had any broken or fractured bones or dislocated joints?	☐	☐
19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches?	☐	☐
20. Have you ever had an x-ray or your neck for atlanto-axial instability? OR Have you ever been told that you have that disorder or any neck/spine problem?	☐	☐
21. Have you ever had a stress fracture of a bone?	☐	☐
22. Do you regularly use a brace or assistive device?	☐	☐
23. Do you currently have a bone, muscle, or joint injury that bothers you?	☐	☐
24. Do any of your joints become painful, swollen, feel warm, or look red?	☐	☐
25. Do you have a history of juvenile arthritis or connective tissue disease?	☐	☐

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
27. Do you have asthma or use asthma medicine (inhaler, nebulizer)?	☐	☐
28. Were you born without or are you missing a kidney, an eye, spleen or any other organ?	☐	☐
29. Do you have groin pain or a painful bulge or hernia in the groin area?	☐	☐
30. Have you had mononucleosis (mono) within the last month?	☐	☐
31. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
32. Have you ever had a herpes or MRSA skin infection?	☐	☐
33. Are you currently taking any medication daily?	☐	☐
34. Have you ever had a head injury or concussion? If so, date of last injury:	☐	☐
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
36. Do you have headaches with exercise?	☐	☐
37. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
38. When exercising in heat, do you have severe muscle cramps or become ill?	☐	☐
39. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
40. Have you had any other blood disorders?	☐	☐
41. Have you had any problems with eyes or vision?	☐	☐
42. Do you wear glasses or contact lenses?	☐	☐
43. Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
44. Do you worry about your weight?	☐	☐
45. Are you trying to or has any professional recommended that you try to gain or lose weight?	☐	☐
46. Do you limit or carefully control what you eat?	☐	☐
47. Do you have any concerns that you would like to discuss with a doctor?	☐	☐
48. What is the date of your last Tdap or Td (tetanus) immunization? (circle type) Date:		
49. Do you have an allergy to medicine, food, or stinging insects?	☐	☐
FEMALES ONLY	**Yes**	**No**
50. Have you ever had a menstrual period?	☐	☐
51. Age when you had your first menstrual period?		
52. How many periods have you had in the last 12 months?		

EXPLAIN "YES" ANSWERS BELOW:

#_____ _____

#_____ _____

#_____ _____

#_____ _____

*List medications and nutritional supplements you are currently taking here: _____

Parent/Guardian Signature _____ Date _____ Athlete's Signature _____