Sports Physical Form

History and General Information (to be completed by athlete or parent/guardian)

Name _____

Home Address _____

_____

Phone _____ Date of Birth _____

Emergency Contact

Name _____ Relationship _____

Phone _____ Alt. Phone _____

Insurance Information

Company/Organization _____

Policy or Contract # _____ Phone _____

Policy Carried through Whom _____

Health History

Have you ever had or currently have	Yes	No
1. Chronic or recurrent illness?	_____	_____
2. Hospitalizations?	_____	_____
3. Surgery?	_____	_____
4. Allergy to medications, food, environment?	_____	_____
5. Problems with heart or blood pressure?	_____	_____
6. Frequent headaches, dizziness, fainting?	_____	_____
7. Seizures, convulsions, concussions?	_____	_____
8. Asthma?	_____	_____
9. Diabetes, hypoglycemia?	_____	_____
10. Eye glasses, contact lenses, dental appliances?	_____	_____
11. Protective equipment or braces?	_____	_____
12. Injuries requiring treatment?	_____	_____
Type and location _____		
_____		
13. Has any family member under age 55 had a heart attack.	_____	_____
14. Are you uncomfortably short of breath after running 1/2 mile without stopping?	_____	_____

If you answered "yes" to any question, please explain or provide additional information.

_____

_____

List all medications you are presently taking and reason for the medication (include asthma inhalers).

_____

Date of last known tetanus shot? _____

_____ _____

Signature of athlete or parent/guardian if under age 18 Date

Sports Physical Form

To be completed by a licensed medical professional

Student Name _____

Height _____ Weight _____ Pulse _____ Blood Pressure _____

Hemoglobin (optional) _____ UA (optional) _____ Other _____

Please evaluate the following as either **normal** or **negative** and add comments below.

1. Appearance _____
2. Eyes, ears, nose, throat _____
3. Mouth and teeth _____
4. Neck _____
5. Heart, pulses _____
6. Chest and lungs _____
7. Abdomen _____
8. Skin _____
9. Genitals; hernia _____
10. Musculoskeletal: ROM, strength, etc. _____
11. Neurological _____
12. Kidneys _____
13. Lymph nodes _____

If you evaluated any of the areas negatively, please explain or provide additional information.

_____

_____

_____

_____

Physician Recommendation

☐ Full Participation ☐ Limited Participation ☐ Not Cleared for Participation

Clearance pending documented follow-up of _____

_____

Medical Professional's Name (printed)

_____

Signature

_____ _____ _____

Address Phone Date