SPORTS PHYSICAL FORM

Name: ______________________________ Gender: M F Date of Birth: ____/____/____

Father's Name: _______________________ Phone: ____________ Email: __________________

Mother's Name: _______________________ Phone: ____________ Email: __________________

Street Address: ____

City:______________________State: _______ Zip Code: __________ Home Phone: _____________

Alternate Emergency Contact Person: __________________________ Phone: _________________

Please indicate MEDICAL ALERTS such as allergic reactions, contact lenses, etc.: _________________

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MEDICAL HISTORY: 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.

Has anyone in the athlete's family (grandparents, mother, father, brother, sister, aunt, uncle) died suddenly before age 50?	YES	NO	Don't Know
Has the athlete ever stopped exercising because of dizziness or passed out during exercise?	YES	NO	Don't Know
Does the athlete have asthma (wheezing), hay fever, coughing spells after exercise?	YES	NO	Don't Know
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
Does the athlete have a history of concussion (getting knocked out)?	YES	NO	Don't Know
Has the athlete ever suffered a heat-related illness (heat stroke)?	YES	NO	Don't Know
Does the athlete have a chronic illness or see a doctor regularly for any particular problem?	YES	NO	Don't Know
Does the athlete take any medication(s)?	YES	NO	Don't Know
Is the athlete allergic to any medications or bee stings?	YES	NO	Don't Know
Does the athlete have only one of any paired organs? (Eyes, ears, kidneys, testicles, ovaries)?	YES	NO	Don't Know
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
Has the athlete had surgery or been hospitalized in the past year?	YES	NO	Don't Know
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
Are you, the athlete, worried about any problem or condition at this time?	YES	NO	Don't Know

Details for any **YES** answers: ____

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PHYSICAL EXAM – TO BE COMPLETED BY PHYSICIAN

Height: ____________ Weight: ____________ Pulse: ______________ Blood Pressure: ___________

Vision: R _____/_____ Uncorrected R _____/______ L _____/_____ Uncorrected L ______/_____

	Normal Findings	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			

Please Print/Stamp

Physician's Name: ________________________________ Practice: ____________________________

Street Address: ____

City, State, Zip Code: ____

Telephone: ______________________________ Fax: ________________________________

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 of Chiropractic Medicine is not satisfactory.)

Physician Signature: ____ Date: __________________

PARTICIPATION RESTRICTIONS: ____

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