

Pre-Participation Sports Physical

(This page to be completed by Physician/Nurse Practitioner/Physician Assistant)

PHYSICAL EXAMINATION

DATE OF EXAM _____

NAME _____ DATE OF BIRTH _____

HEIGHT _____ WEIGHT _____ % BODY FAT (optional) _____ PULSE _____ BP _____

	NORMAL	ABNORMAL FINDING
<u>MEDICAL</u>		
Appearance		
Eyes/Ears/Nose/Throat		
Lymph nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		
<u>MUSCULOSKELETAL</u>		
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		

CLEARANCE

Cleared

Cleared after completing evaluation/rehabilitation for: _____

Not Cleared for [Sport(s)]: _____ Reason: _____

Recommendation: _____

Name of Physician/Nurse Practitioner/Physician Assistant _____ Date: _____

Address: _____ Phone: _____

Signature of Physician/Nurse Practitioner/Physician Assistant _____

Pre-Participation Physical Evaluation

(This page to be completed by Student and Parent/Guardian)

Name _____	Sex _____	Age _____	Grade _____	Date of Birth _____
Address _____				
Personal physician _____ Dr. Phone Number _____				
In case of emergency, contact: Name _____				
Relationship to Child _____		Phone (H) _____	(C) _____	

*** Explain "Yes" answers below. Circle questions if you don't know the answers.

YES **NO**

1. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler? Have you been diagnosed with asthma? Have you been prescribed by a physician to use any asthma medication? Do you have a current consent form to self-administer the asthma medication on file with the school?	_____	_____
2. Do you have any allergies (for example: medicines, foods, stinging insects, pollen)? Do you have seasonal allergies that require medical treatment? Do you cough, wheeze or have trouble breathing during or after activity? Have you ever had a rash or hives develop during or after exercise?	_____	_____
3. Do you have an ongoing chronic or serious illness (example: diabetes, bleeding disorders, etc.)? Do you have any known deformities (for example: curvature of the spine, heart problems, blindness in one eye)?	_____	_____
4. Have you ever been hospitalized overnight? Have you ever had surgery? Have you had a medical illness or injury since your last check up or sports physical?	_____	_____
5. 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 get tired more quickly than your friends do during exercise? Have you ever had racing of your heart or skipped heartbeats? Have you had high blood pressure or high cholesterol? Have you ever been told you have a heart murmur? Has any family member or relative died of heart problems or of sudden death before age 50? Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? Has a physician ever denied or restricted your participation in sports for any heart problems?	_____	_____
6. Have you ever become ill from exercising in the heat?	_____	_____
7. Have you ever had a head injury or concussion? Have you ever been knocked out, become unconscious, or lost your memory? Have you ever had a seizure? Do you have frequent or severe headaches? Have you ever had numbness or tingling in your arms, hands, legs, or feet? Have you ever had a stinger, burner, or pinched nerve?	_____	_____
8. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	_____	_____
9. Have you had any problems with your eyes or vision? Do you wear glasses, contacts, or protective eyewear?	_____	_____
10. Have you ever had a sprain, strain, or swelling after injury? Have you broken or fractured any bone, or dislocated any joints? Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? If yes, check appropriate box and explain below. ____ Head ____ Upper Arm ____ Hand ____ Knee ____ Back ____ Elbow ____ Finger ____ Shin/Calf ____ Chest ____ Forearm ____ Hip ____ Ankle ____ Shoulder ____ Wrist ____ Thigh ____ Foot	_____	_____

11. Record the dates of your most recent immunizations (shots) for:

Tetanus _____ Measles _____ Hepatitis B _____ Chickenpox _____

EXPLAIN "Yes" answers here: _____

In case of emergency, I/We hereby authorize my child to be treated by an available licensed physician. It is our understanding that every effort will be made to contact us immediately in case of such emergency.

We also hereby state that, to the best of our knowledge, our answers to the above questions are complete and correct.

Signature of Parent/Guardian _____ Date _____

Signature of Athlete _____ Date _____