

SPORTS PHYSICAL EXAMINATION FORM

LAST NAME		FIRST NAME		GRADE
BIRTHDATE	FALL SPORT	WINTER SPORT	SPRING SPORT	STUDENT ID NUMBER

HEALTH HISTORY (Must be Completed Prior to the Examination)

	Yes	No	Has this student had any:	Yes	No	Does this student:
1.	<input type="checkbox"/>	<input type="checkbox"/>	Chronic or recurrent illness?	16.	<input type="checkbox"/>	Wear eyeglasses or contact lenses?
2.	<input type="checkbox"/>	<input type="checkbox"/>	Illness lasting over 1 week?	17.	<input type="checkbox"/>	Wear dental bridges, braces or plates?
3.	<input type="checkbox"/>	<input type="checkbox"/>	Hospitalizations or Surgery?	18.	<input type="checkbox"/>	Take any medications? (List below):
4.	<input type="checkbox"/>	<input type="checkbox"/>	Nervous, psychiatric, or neurologic condition?			
5.	<input type="checkbox"/>	<input type="checkbox"/>	Loss or nonfunctioning of organs (eye, kidney, liver, testicle) or glands?	Yes	No	Is there any history of:
6.	<input type="checkbox"/>	<input type="checkbox"/>	Allergies (medicines, insect bites, food)?	19.	<input type="checkbox"/>	Injuries requiring medical care or treatment?
7.	<input type="checkbox"/>	<input type="checkbox"/>	Problems with heart or blood pressure?	20.	<input type="checkbox"/>	Neck or back pain or injury?
8.	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain or severe shortness of breath with exercise?	21.	<input type="checkbox"/>	Knee pain or injury?
9.	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness or fainting with exercise?	22.	<input type="checkbox"/>	Shoulder or elbow pain or injury?
10.	<input type="checkbox"/>	<input type="checkbox"/>	Fainting, bad headaches or convulsions?	23.	<input type="checkbox"/>	Ankle pain or injury?
11.	<input type="checkbox"/>	<input type="checkbox"/>	Concussion or loss of consciousness?	24.	<input type="checkbox"/>	Other joint pain or injury?
12.	<input type="checkbox"/>	<input type="checkbox"/>	Heat exhaustion, heatstroke, or other problems with heat?	25.	<input type="checkbox"/>	Broken bones (fractures)?
13.	<input type="checkbox"/>	<input type="checkbox"/>	Racing heart, skipped, irregular heartbeats, or heart murmur?	Yes	No	Further history:
14.	<input type="checkbox"/>	<input type="checkbox"/>	Seizures?	26.	<input type="checkbox"/>	Birth defects (corrected or not)?
15.	<input type="checkbox"/>	<input type="checkbox"/>	Severe or repeated instances of muscle cramps?	27.	<input type="checkbox"/>	Death of parent or grandparent less than 40 years of age due to medical cause or condition?
Date of last known tetanus (lockjaw) shot: _____				28.	<input type="checkbox"/>	Parent or grandparent requiring treatment for heart condition less than 50 years of age
Date of last complete physical examination: _____				29.	<input type="checkbox"/>	Been seen by a physician on an emergency or urgent basis in the last 12-months?

Explain all "YES" answers here along with any other fact or circumstance that should be disclosed prior to the examination (use reverse of form if needed):

PARENT/GUARDIAN'S AUTHORIZATION: I authorize a physician or duly authorized and supervised physician's assistant or nurse practitioner to perform a Sports Physical Evaluation on the student. The information set forth above is complete and accurate and I know of no reason why the student cannot fully and safely participate in the listed sports. I understand that this is solely a screening examination and that the absence of any health conditions or concerns listed below does not mean that student is free from actual or potential harmful health conditions that may cause the student injury or death while participating in sports. Any question or concern I may have regarding the student's health or safety will be referred to our personal physician or health care provider for review and evaluation.

PRINT NAME OF PARENT OR GUARDIAN		SIGNATURE OF PARENT OR GUARDIAN		
ADDRESS		WORK PHONE	HOME PHONE	DATE
REGULAR PHYSICIAN'S NAME		OFFICE PHONE		

PART 2 (TO BE COMPLETED BY THE EXAMINING PHYSICIAN/PHYSICIAN'S ASSISTANT/NURSE PRACTITIONER)

	NORMAL	ABNORMAL (Describe)	
Eyes/Ears/Nose/Throat			Height:
Skin			Weight:
Heart			Pulse: After Ex:
Abdomen			BP:
Genital/hernia (males)			Recommendation: <input type="checkbox"/> Unlimited participation <input type="checkbox"/> Limited participation/specific sports, events or activities <input type="checkbox"/> Clearance withheld pending further testing/evaluation <input type="checkbox"/> No athletic participation One of the above <u>MUST</u> be checked.
Musculoskeletal:			
a. Neck/Spine/Shoulders/Back			
b. Arms/Hands/Fingers			
c. Hips/Thighs/Knees/Legs			
d. Feet/Ankles			
Neurologic Screening Exam (NSE)			

Comments:

PRINT NAME OF PHYSICIAN (M.D., D.O., P.A., or N.P. only)	PHYSICIAN'S SIGNATURE	DATE	SIA 9/09 (English) Page 1 of 1
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