Sports Physical

Student or Parent: Please complete this side of the form.

Name:_____ **Age**_____ **Grade**_____ **Male Female**

Check the sport(s) that you will be playing: (Fall_____ Winter_____ Spring_____)

Baseball Basketball Cheerleading Cross-Country Football
Golf Wrestling Volleyball Soccer Softball Track/Field
Other:_____

	YES	NO
Have you ever been hospitalized? If yes what for?		
Have you ever had surgery? If yes please list what kind:		
Are you currently taking medications/supplements? If yes please list:		
Do you have any allergies (e.g. medications, bee stings)? If yes please list and describe reaction:		
Have you ever passed out during exercise (not from heat)?		
Have you ever been dizzy during exercise (not from heat)?		
Have you ever had chest pain?		
Have you ever had high blood pressure?		
Have you ever been told you have a heart murmur?		
Has your heart ever raced or skipped beats?		
Has anyone in your family died of heart problems or sudden death at age 40 or younger?		
Does anyone in your family have Marfan's syndrome?		
Do you have any skin problems (e.g. itching, rashes, breaking out)?		
Have you ever had a head injury (e.g. knocked out or had a concussion)? If yes please explain:		
Have you ever had a seizure?		
Have you ever had neck pain or a neck injury?		
Do you cough or wheeze when exercising?		

Have you ever injured (broken/fractured, sprained, dislocated) any of the following areas?
If yes check all that apply:

Ankle Back Chest/Ribs Elbow Foot/Toes Forearm Hand/Fingers Hip
Knee Neck Shin/Calf Shoulder Thigh Upper Arm Wrist

Have you ever had or do you currently have any of the following medical problems? If yes check all that apply:

Asthma Diabetes Eye/Ear Injuries Headache (frequent) Hepatitis Hernia(s) Measles
Mononucleosis Sickle Cell Trait/Disease Stomach Ulcer(s) Tuberculosis Any Stress Fractures

When was your last tetanus shot?_____

For Females:
When was your first period?_____ How old were you?_____ When was your last period?_____
Are your periods: Regular/Monthly Irregular/Skip Months

Please feel free to ask the provider to address any questions/concerns you have. All discussions are kept confidential. The above information is current and correct to the best of my knowledge.

Parent/Guardian Signature:_____ Date_____

Physical Examination

Yuma District
Hospital and
Clinics
1000 W 8th Ave
Yuma, CO 80759
970-848-5405

Name:_____

Date of Birth:_____

Nurse to complete this section:

Height_____ BP_____

Weight_____ Pulse_____

Provider to complete this section:

	Normal		Normal
1. Skin	_____	9. Abdomen	_____
2. Head	_____	10. Extremities	_____
3. Eyes	_____	11. Neurologic	
4. Ears, Nose, Throat	_____	Reflexes	_____
5. Neck	_____	12. Orthopedic	
6. Lymphatic's	_____	Cervical spine/back	_____
7. Respiratory	_____	Arms/elbows/wrists/hands	_____
8. Cardiovascular		Hips	_____
Heart (murmurs)	_____	Knees	_____
Pulses (radial/femoral)	_____	Ankles/feet	_____

Comments/Recommendations:_____

_____

_____

_____

_____

Medical Clearance (as appropriate for age and development)

Full Contact/Collision Level

Limited Contact/Impact

Noncontact: Strenuous

Noncontact: Non-strenuous

Clearance deferred or no participation at this time because:_____

_____

_____

Provider Signature:_____ **MD/DO/FNP/PA Date:** _____