Physical Evaluation Form **(This page to be completed by parent/guardian)**

Name: ______________________________________ Sex: M F Age: ___ Date of birth: _________ Grade: _____

Sports: Football Boys Soccer Volleyball Boys Basketball Girls Basketball Wrestling Softball Baseball Tennis Girls Soccer Track & Field

Address:____ Phone: _________________

Parent/Guardian: _________________________ Phone (W): ____________________ Phone (C): ________________

History Form

Circle answer to questions and explain "Yes" answers below.

1. Has a doctor ever denied or restricted your participation in sports for any reason? Yes No
2. Do you have an ongoing medical condition (like diabetes or asthma)? Yes No
3. Have you ever used an inhaler or taken asthma medicine? Yes No
4. Are you currently taking any prescription or nonprescription (over-the-counter) medicines? Yes No
5. Do you have allergies to medicines, pollens, foods or stinging insects? Yes No
6. Have you ever passed out or nearly passed out DURING exercise? Yes No
7. Have you ever passed out or nearly passed out AFTER exercise? Yes No
8. Do you cough, wheeze, or have difficulty breathing during or after exercise? Yes No
9. Have you ever had discomfort, pain, or pressure in your chest during exercise? Yes No
10. When exercising in the heat, do you have server muscle cramps or become ill? Yes No
11. Does your heart race or skip beats during exercise? Yes No
12. Has a doctor ever told you that you have ☐ Heart murmur ☐ High blood pressure Yes No
13. Has a doctor ever ordered a test for your heart? Yes No
14. Has any family member ever had/have heart problems? Yes No
15. Have you ever spent the night in a hospital? Yes No
16. Have you ever had surgery? Yes No
17. **Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis that caused you to miss a practice or game? Yes No**
18. **Have you had a broken or fractured bones or dislocated joints? Yes No**
19. **Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? Yes No**
20. **Have you ever had a head injury or concussion? Yes No**
21. Have you ever had a seizure? Yes No
22. Have you ever been unable to move your arms or legs after being hit or failing? Yes No
23. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? Yes No
24. Have you ever had a stress fracture? Yes No
25. Were you born without or are you missing a kidney or any other organ? Yes No
26. Do you have any rashes, pressure sores, or other skin problems? Yes No
27. Do you wear glasses or contact lenses? Yes No
28. Do you have any concerns that you would like to discuss with the doctor? Yes No

Explain "yes" answers here:

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I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Athlete: _______________________ Signature of Parent/Guardian: ___________________ Date: ________

PHYSICAL EXAMINATION FORM
(to be completed by physician)

Date of Exam: __________________

Last name: ____________________ First Name: ____________________ Date of Birth: __________ Grade: ___

Height__________ Weight___________ Pulse_________ BP__________/__________

Vision R 20/____ L 20/____ Corrected: Y N Pupils: Equal______ Unequal_____

Medical	**Normal**	**Abnormal**	**Musculoskeletal**	**Normal**	**Abnormal**
Appearance			Neck		
Eyes/ears/nose/throat			Back		
Hearing			Shoulder/arm		
Lymph nodes			Elbow/forearm		
Heart			Wrist/hand/fingers		
Murmurs			Hip/thigh		
Pulses			Knee		
Lungs			Leg/ankle		
Abdomen			Foot/toes		
Skin					

Notes: ____
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PHYSICIAN'S CLEARANCE

☐ Cleared without restriction for ALL SPORTS

☐ Cleared without restriction for certain sports ____________________________

☐ Cleared, with recommendations for further evaluation or treatment for: ____________________________

☐ Not cleared – Reason ____

Recommendations:

EMERGENCY INFORMATION:
Allergies ____

Other Information ____

Name of physician (print/type) ____ Date ___________________

Address ____ Phone ______________________

Signature of physician __________________________________, MD or DO

Address/Facility stamp *(physical will not be accepted without stamp)*

To be completed by school: Initials __________ Date Received ___________ Data Entry Date _________

Activity: Football Boys Soccer Volleyball Cheerleader Boys Basketball Girls Basketball Wrestling Softball Baseball Tennis Girls Soccer Track & Field