



Part 1. Student Information (to be completed by the parent).

Student Name: _____ Sex: _____ Age _____ Date of Birth _____ / _____ / _____

School: _____ Grade in School _____ Sport(s) expected to play _____

Home Address: _____ Home Phone () _____

Name of Parent/Guardian: _____

Person to Contact in Case of Emergency: _____

Relationship to Student: _____ Home Phone: () _____ Work Phone: () _____

Personal/Family Physician: _____ City/State: _____ Office Phone: () _____

Part 2. Medical History (to be completed by parent). Explain "yes" answers below. Circle questions for which you do not know the answer

	Yes	No		Yes	No
1. Has child had a medical illness or injury since the last check up or sports physical?	_____	_____	26. Has child ever become ill from exercising in the heat?	_____	_____
2. Does child have an ongoing chronic illness?	_____	_____	27. Does child cough, wheeze or have trouble breathing during or after activity?	_____	_____
3. Has child ever been hospitalized overnight?	_____	_____	28. Does child have asthma?	_____	_____
4. Has child ever had surgery?	_____	_____	29. Does child have seasonal allergies that require medical treatment?	_____	_____
5. Is child currently taking any prescription or nonprescription (over the counter) medications or pill or using an inhaler?	_____	_____	30. Does child have 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)?	_____	_____
6. Has child ever taken any supplements or vitamins to help gain or lose weight or improve performance?	_____	_____	31. Has child had any problems with his/her eyes or vision?	_____	_____
7. Does child have any allergies (for example to pollen, medicine, food or stinging insects)?	_____	_____	32. Does child wear glasses, contacts, or protective eye wear?	_____	_____
8. Has child ever had rash or hives develop during or after exercise?	_____	_____	33. Has child ever had a sprain, strain, or swelling after injury?	_____	_____
9. Has child ever passed out during or after exercise?	_____	_____	34. Has child broken or fractured any bones or dislocated any joints?	_____	_____
10. Has child ever been dizzy during or after exercise?	_____	_____	35. Has child had any other problems with pain or swelling in muscles, tendons, bones, or joints?	_____	_____
11. Has child ever had chest pain during or after exercise?	_____	_____	<i>If yes, check appropriate blank and explain below:</i>		
12. Does child get tired more quickly than friends during exercise?	_____	_____	___ Head	___ Elbow	___ Hip
13. Has child ever had racing of the heart or skipped heartbeats?	_____	_____	___ Neck	___ Forearm	___ Thigh
14. Has child had high blood pressure or high cholesterol?	_____	_____	___ Back	___ Wrist	___ Knee
15. Has child ever been told he/she has a heart murmur?	_____	_____	___ Chest	___ Hand	___ Shin/Calf
16. Has any family member or relative died of heart problems or sudden death before age 50?	_____	_____	___ Shoulder	___ Finger	___ Ankle
17. Has child had severe viral infection (for example, myocarditis or mononucleosis) within the last month?	_____	_____	___ Upper Arm	___ Foot	
18. Has a physician ever denied or restricted child's participation in sports for any heart problems?	_____	_____	36. Does child want to weigh more or less than child weighs now?	_____	_____
19. Does child have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	_____	_____	37. Does child lose weight regularly to meet weight requirements for a sport?	_____	_____
20. Has child ever had a head injury or concussion?	_____	_____	38. Does child feel stressed out?	_____	_____
21. Has child ever been knocked out, become unconscious, or lost his/her memory?	_____	_____	39. Record the dates of his/most recent immunizations (shots) for:		
22. Has child ever had a seizure?	_____	_____	Tetanus _____	Measles: _____	
23. Does child have frequent or severe headaches?	_____	_____	Hepatitis B _____	Chickenpox: _____	
24. Has child ever had numbness or tingling in his/her arms, hands, legs, or feet?	_____	_____			
25. Has child ever had a stinger, burner, or pinched nerve?	_____	_____			

Explain "Yes" answers here: _____

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

Signature of Parent/Guardian _____ Date: _____



Part 3. Physical Examination (to be completed by physician).

Student Name: _____ Date of Birth _____ / _____ / _____

Height: _____ Weight: _____ % Body Fat (optional): _____ Pulse: _____ Blood Pressure: _____ / _____ (_____ / _____ , _____ / _____)

Visual Acuity: Right 20/ _____ Left 20/ _____ Corrected: Yes No Pupils: Equal _____ Unequal _____

FINDINGS	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
1. Appearance	_____	_____	_____
2. Eyes/Ears/Nose/Throat	_____	_____	_____
3. Lymph Nodes	_____	_____	_____
4. Heart	_____	_____	_____
5. Pulses	_____	_____	_____
6. Lungs	_____	_____	_____
7. Abdomen	_____	_____	_____
8. Skin	_____	_____	_____
MUSCULOSKELETAL			
9. Neck	_____	_____	_____
10. Back	_____	_____	_____
11. Shoulder/Arm	_____	_____	_____
12. Elbow/Forearm	_____	_____	_____
13. Wrist/Hand	_____	_____	_____
14. Hip/Thigh	_____	_____	_____
15. Knee	_____	_____	_____
16. Leg/Ankle	_____	_____	_____
17. Foot	_____	_____	_____

* - Station-based examination only

ASSESSMENT OF EXAMINING PHYSICIAN

____ Cleared without limitation
 ____ Not cleared for _____ Reason _____
 ____ Cleared after completing evaluation/rehabilitation for: _____
 ____ Referred to _____ For _____

Recommendations: _____

Name of Physician (print or type): _____ Date: _____

Address: _____

Signature of Physician: _____, MD, DO, DC, ARNP

ASSESSMENT OF PHYSICIAN TO WHOM REFERRED (if applicable)

I hereby certify that the examination(s) for which referred was/were performed by myself or an individual under my direct supervision with the following conclusion(s)

____ Cleared without limitation
 ____ Not cleared for _____ Reason _____
 ____ Cleared after completing evaluation/rehabilitation for: _____
 ____ Referred to _____ For _____

Recommendations: _____

Name of Physician (print or type): _____ Date: _____

Address: _____

Signature of Physician: _____, MD, DO, DC, ARNP