



SPORTS PHYSICAL PHYSICIAN OFFICE FORM

Name: _____ Date of Birth: _____ Student ID: _____

Sports: _____ School: _____ Grade: ____ Male Female

EXPLAIN YES ANSWERS BELOW CIRCLE QUESTIONS YOU DO NOT UNDERSTAND

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Has a doctor ever denied or restricted your participation in sports? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have a medical condition (asthma/diabetes)? | <input type="checkbox"/> | <input type="checkbox"/> |

CARDIAC RISK:

- | | | |
|---|--------------------------|--------------------------|
| 1. Has any relative died of a heart condition suddenly before age 50? | <input type="checkbox"/> | <input type="checkbox"/> |
|---|--------------------------|--------------------------|

Do you or your relatives have a history of:

- | | | |
|---|--------------------------|--------------------------|
| a. Heart muscle disease such as hypertrophic cardiomyopathy? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Arrhythmia, irregular rhythm, pacemaker WPW (Wolf Parkinson White), Long QT syndrome or other cardiac problem? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Marfan Syndrome? | <input type="checkbox"/> | <input type="checkbox"/> |

- | | | |
|---|--------------------------|--------------------------|
| 3. Does your heart race or skip beats during exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had chest pain during exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever passed out or nearly passed out during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have a history of high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. History of a heart murmur (other than innocent murmur) or other heart problem? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. History of unexplained dizziness with exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever had an ECG or Echocardiogram test for your heart? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. History of congenital heart disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. History of Carditis or Kawasaki disease? | <input type="checkbox"/> | <input type="checkbox"/> |

RESPIRATORY RISK:

- | | | |
|---|--------------------------|--------------------------|
| 1. History of cough, wheezing, or difficulty breathing during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever used an inhaler or taken asthma medication? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have a history of severe allergies to pollens, stinging insects, foods, or grasses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever been told by a doctor that you have asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. History of fractured ribs in the last 6 weeks? | <input type="checkbox"/> | <input type="checkbox"/> |

NEUROLOGICAL RISK:

- | | | |
|--|--------------------------|--------------------------|
| 1. History of head or neck injury, or concussion? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever had amnesia or memory loss after a head injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or or falling? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. History of seizures? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. History of headaches with exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have a history of any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you wear glasses or contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. History of neck instability | <input type="checkbox"/> | <input type="checkbox"/> |

INFECTION RISK:

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Do you have a history of recurrent or persistent rashes, pressure sores, herpes, or other skin infections? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been diagnosed or treated for a MRSA infection? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. History of Mono (EBV) in the last 4 weeks? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. History of recurrent unexplained fevers, or chronic coughing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you or any members of your household have a history of tuberculosis or positive PPD? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. History of Hepatitis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. History of HIV? | <input type="checkbox"/> | <input type="checkbox"/> |

ORTHOPEDIC RISK:

- | | | |
|--|--------------------------|--------------------------|
| 1. Have you ever broken any bones? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. History of neck or back injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. History of chronic back or neck pain? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. History of ankle, knee, hip injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. History of wrist, elbow, shoulder injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have any artificial limbs or prosthetic devices (false teeth)? | <input type="checkbox"/> | <input type="checkbox"/> |

OTHER PERTINENT QUESTIONS:

- | | | |
|--|--------------------------|--------------------------|
| 1. Are you taking any prescription or nonprescription (over the counter) medicines or pills? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you taking supplements or medications to gain or lose weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you taking medications or supplements to increase your strength or improve your sports performance? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you trying to gain or lose weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Were you born without or are you missing a kidney, eye, (if male testicle), (if female ovary) or other organ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. History of bleeding or clotting disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. History of severe muscle cramps or feeling severely ill when exercising in the heat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. History of surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. History of enlarged liver or spleen? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. History of sickle cell disease/trait? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. History of Hypoglycemia (low blood sugar)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Any medical changes since your last physical? | <input type="checkbox"/> | <input type="checkbox"/> |

FEMALES OLDER THAN 16 (OPTIONAL):

- | | | |
|---|--------------------------|--------------------------|
| 1. Have you had no periods? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you gone more than 90 days without a period in the last 6 months? | <input type="checkbox"/> | <input type="checkbox"/> |

EXPLAIN "YES" ANSWERS HERE: _____

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: _____

Physician's Sport Physical Form

WE WILL ONLY ACCEPT EXAMS COMPLETED BY MD'S DO'S OR NP'S

I grant permission to release the information below to School Personnel.

Signature of Parent/Guardian: _____

NAME: _____ Date of Birth: _____ Student ID: _____
 Sports: _____ School: _____ Grade: _____
 Emergency Contact: _____ Cell Phone: _____ Home Phone: _____
 ALLERGIES: _____ MEDICATIONS: _____

Date of Exam: _____ Height: _____ Weight: _____ BMI: _____ Pulse: _____ BP: _____/_____

HEARING: Passed Right/Left ≤ 25 dbcls (all frequencies) Vision: R 20/____ L 20/____ Both 20/____ Corrected: Y N
 Failed _____ Not Done U/A: Normal _____

REQUIRED IMMUNIZATIONS: Measles, Mumps, Rubella, Hepatitis B, Polio, Tetanus, Pertussis, and Varicella/illness.

Up to date (See Attached Vaccine Documentation)

Not up to date, Vaccines Needed: _____

Date: _____ Baseline Concussion Assessment Completed (if not done, school will conduct the screening)

MEDICAL:	NORMAL	ABNORMAL FINDINGS
General Appearance		
Head eyes/ears/nose/throat		
Neck		
Respiratory		
Heart		
Pulses		
Abdomen		
Skin		
Neuro		
Lymph Nodes		
Genitourinary (males only)		
MUSCULOSKELETAL:	NORMAL	ABNORMAL FINDINGS
Back (including scoliosis screen)		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		

Assessment/Plan: _____

Cleared for all sports without restrictions

Not Cleared for: All sports Certain sports: _____

Reason: _____

Deferred requires further evaluation (See Recommendations Below):

Cleared with restrictions (See Recommendations Below):

Official Office Stamp (required)

Recommendations: _____

Name of Physician (print): _____ Address: _____ Phone: _____

Signature of Physician: _____, M.D., D.O., or N.P. Date: _____