

ATHLETIC PHYSICAL EXAMINATION FORM

NAME _____ GRADE _____
Last First

FEMALE _____ MALE _____ BIRTHDATE _____ PHONE _____

Health history to be completed by parent/guardian and reviewed by examining physician
Answer all questions by circling "yes" or "no"

- | | | |
|--|-----|----|
| 1. Respiratory Problems (Asthma) | YES | NO |
| a. Do you cough or wheeze with exercise? | YES | NO |
| b. Are you under medical care for asthma? | YES | NO |
| c. Do you use an inhaler? | YES | NO |
| d. How often do you use rescue inhaler for relief: # per day _____; # per week _____ | | |
| 2. Has had an injury of a muscle, bone, joint, ligament or tendon | YES | NO |
| Was medical attention required? When _____ What _____ | YES | NO |
| 3. Has been knocked out. If yes, how many times? _____ | YES | NO |
| 4. Has fainted. If yes, how many times? | YES | NO |
| 5. History of seizures (convulsions/epilepsy) | YES | NO |
| 6. Diabetes | YES | NO |
| 7. Rheumatic Fever | YES | NO |
| 8. Absent or undescended testicle | YES | NO |
| 9. Hernia | YES | NO |
| 10. Is under a physician's care now | YES | NO |
| 11. Takes any medication now. Name of medication(s) _____ | YES | NO |
| 12. Wears glasses | YES | NO |
| Wears contact lens | YES | NO |
| 13. Dental bridge or false teeth | YES | NO |
| 14. Has had a surgical operation | YES | NO |
| 15. Has been in a hospital (except for tonsillectomy) | YES | NO |
| 16. Do you know of any reason why this student should NOT participate in any sport? | YES | NO |
| 17. Any allergies (Bee stings, etc.) | YES | NO |
| 18. Difficult Menses? | YES | NO |

Please explain any "YES" answers to the above questions: _____

Signature of Parent/Guardian: _____ Date: _____

• Reverse side to be completed by examining physician •

ATHLETIC PHYSICAL EXAMINATION FORM

· To be completed by examining physician ·

Name _____ Age _____
Last First

Height _____ Weight _____ Blood Pressure _____ Pulse _____

Eyes R 20/ _____ Glasses _____ Contact Lenses _____
L 20/ _____

Ears _____ Nose _____ Throat _____

Dental Evaluation (Missing teeth? Chipped teeth?
Dental Bridge? False teeth?) _____

Respiratory impairment? _____

Cardiovascular abnormalities? _____

Musculoskeletal evaluation:

Neck, shoulder girdle or upper extremity _____
Abnormalities? _____
Limitation of movement? _____

Trunk _____
Rib abnormalities? _____

Thigh and knee _____
Hamstring or quadriceps abnormality? _____
Knee ligament and stability? _____
Knee joint effusion or crepitation? _____

Calf, ankle and foot _____
Achilles tendon disorder? _____
Ankle ligament stability? _____
Ankle joint effusion or crepitation? _____
Foot problems? _____
Limitation of movement? _____

Neurological evaluation _____

Genitalia _____
Laboratory: Urinalysis _____

This student was examined by me and no physical condition was detected which would reasonably be anticipated to render this athlete physically unfit to engage in any sport, except _____. If none state "none".

Examining Physician _____ Date _____

Address _____ Phone _____