

PHYSICIAN USE ONLY

BLOOD PRESSURE _____ HEIGHT _____

WEIGHT _____ VISION: Corrected? YES _____ NO _____

Glasses _____ Contacts _____

	NORMAL	ABNORMAL	FINDINGS
HEENT			
SKIN			
HEART			
LUNGS			
EXTREMITIES			

While this does not constitute a complete physical examination, this individual appears to be physically capable of participating in interscholastic sports as of this date. Unless otherwise indicated below.

- Clear for sports and activities without reservations
- Cleared with the following restrictions: _____

- Cleared after completing evaluation/rehabilitation for: _____
- Not cleared: Recommendations: _____

PHYSICIANS NAME _____ PHONE _____

PHYSICIANS SIGNATURE _____ DATE _____

SPORTS & ACITIVITES PARTICIPATION PHYSICAL

NAME: _____ DATE _____

AGE _____ GRADE _____ ACTIVITES _____

Place a check in the box of any questions that you can answer, YES.

- Are you under a doctor's care for any reason?
- Have you ever been hospitalized?
- Have you ever had surgery?
- Are you currently taking any medication, inhalers or pills?
- Do you have any allergies? (Bee stings, medicines)
- Have you ever been dizzy or passed out during or after exercise?
- Have you ever had high blood pressure?
- Have you ever been told you have a heart murmur?
- Have you ever had racing of your heart or skipped heartbeats?
- Have you ever had a head injury?
- Have you ever been knocked out or unconscious?
- Have you ever had a seizure?
- Have you have had stinger, burnner or pinched nerve?
- Have you ever been dizzy or passes out in the heat?
- Do you have trouble breathing or coughing during or after exercise?
- Do you have any skin problems such as rashes, itching, etc?
- Do you have any problems with your eyes or with your vision?
- Do you wear contacts, glasses or protective eye wear?
- Do you have any special equipment such as splints, neck rolls, mouth guards, etc?
- Has anyone in your family died of heart problems or sudden death before the age of 50?
- Do you have only one working organ of usually paired organs (kidneys/eyes)?
- Have you ever sprained, broken, dislocated or repeated swelling of any bones or joints?

Circle any of the following below that answers YES to the above question

HEAD	NECK	CHEST	SHOULDER	BACK
HAND	WRIST	ELBOW	FOREARM	HIP
THIGH	KNEE	ANKLE	SHIN/CALF	FOOT

- Do any of the above currently bother you?
- Do you have any other medical problems such as asthma, mono, diabetes, etc?
- Have you have any medical injuries since your last medical evaluation?
- Any special instructions or precautions?
- When was your last tetanus shot?
- Do you use any tobacco products?
- (WOMEN ONLY) Are you having regular periods?

IF YOU HAVE CHECKED OFF ANY OF THE ABOVE QUESTIONS, PLEASE EXPLAIN IN THE SPACE BELOW. IF MORE ROOM IS NEEDED PELASE USE THE BOTTOM OF THE BACKSIDE OF THIS PAGE _____

I/WE HEREBY STATE THAT TO THE BEST OF MY/OUR KNOWLEDGE, THE ANSWERS ARE CORRECT. I/WE UNDERSTAND THAT BY PERFORMING THIS EXAMINATION, THE UNDERSIGNED PHYSICIAN DOES NOT ASSUME RESPOINSIBILITY FOR THE MEDICAL CARE OF THIS INDIVIDUAL.

Signature required below:

ATHLETE _____ PARENT/GUARDIAN _____