

Name: _____
last first

MALE / FEMALE Birthdate: _____

Address: _____

Phone: _____

Sports: _____

School: _____

1. Have you been absent from school or unable to play sports because of illness or injury in the past? YES ___ NO ___

If yes, how many times? _____ For what reason? _____

2. Do you take medication or treatment regularly? YES ___ NO ___ What? _____

3. Are you allergic to anything? YES ___ NO ___ What? _____

4. Family History: Have any blood relatives (parents, siblings) had:

Check each item	YES	NO	Relationship
Diabetes			
Heart trouble			
Stroke or High Blood Pressure			
Asthma or Allergies			
Blood disease, Cancer			

5. Please list all hospitalizations and operations, including years:

Operations / Hospitalizations	Year

6. Have you ever had or have now:

	YES	NO
Seizures; fainting or dizzy spells		
Diabetes (sugar in urine)		
Heart trouble; chest pains; murmur		
Lung problems; difficulty breathing		
Asthma; Bronchitis		
Hernia		
Ear, Nose, Throat, or Sinus problems		
Broken/Fractured bones		
Worn a splint, cast, or brace		
Where?		
Back pain or injury		
Neck injury		

7. Have you ever had any injury to or pain or swelling in any of the following:

	YES	NO
Shoulders		
Arms		
Wrists		
Hands		
Legs		
Knees		
Ankles		

8. Are your immunizations up to date? YES ___ NO ___

The above answers are true to the best of my knowledge and belief and constitute a full and complete disclosure of my knowledge with respect to the questions asked.

Signature of athlete: _____ Date: _____

Consent to Treatment:

The undersigned authorizes the physician assigned to furnish medical services for purposes of the sports medicine physical examinations as are deemed necessary to assess the patient's physical fitness to participate in athletics. I am aware that the practice of medicine is not an exact science, and I acknowledge that the physicians conducting physical exams have not made any guarantees as to the results that may be obtained or the consequences that may follow.

Signature of Parent/Guardian: _____ Date: _____

Height	Weight	Blood pressure	Pulse

Vision: ___ Abnormal ___ Normal **RIGHT:** 20/ 200 100 70 50 40 30 20/20

Acuity: ___ Uncorrected ___ Corrected **LEFT:** 20/ 200 100 70 50 40 30 20/20

	Normal	Abnormal	Knees/ankles		Shoulder R / L	Normal	Abnormal
			Normal	Abnormal			
Posture: (circle what applies)			Knee lig. Stability R / L				
Scoliosis leg length			ACL,PCL,MCL,LCL		ROM		
Lordosis valgus			Patellar alignment		Impingement Sign		
Scoliosis varus			Meniscus Med/Lat		Joint stability		
			Ankle Lig. Stab. Med/Lat		Apprehension sign		
Flexibility R / L (circle what applies)			Ankle Lig. Stab. R / L		Supraspinatus test		
Sit & reach Calf			Ant drawer R / L		Strength		
Quads Hamstring			Supination R / L				
			Pronation R / L				
	Normal	Abnormal					
Heart							
Lungs							
Abdomen							
ENT							
Other: _____							

Recommendations: _____

I certify that I have examined the above student and recommend him/her as being able to compete in supervised athletic activities not crossed out below:

BASEBALL - BASKETBALL - BOWLING - CHEER/POM - CROSS COUNTRY - FOOTBALL - GOLF - GYMNASTICS - HOCKEY - LACROSSE - MARCHING BAND - SKIING - SOCCER - SOFTBALL - SWIMMING - TENNIS - TRACK - VOLLEYBALL - WRESTLING

Name/Credentials of Examiner: _____ Signature: _____ Date: _____

A CURRENT YEAR PHYSICAL IS ONE GIVEN ON OR AFTER APRIL 15TH OF THE PREVIOUS SCHOOL YEAR