

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		Yes	No
1. Has a doctor ever denied or restricted your participation in sports?	<input type="checkbox"/>	<input type="checkbox"/>	INFECTION RISK:		
2. Do you have a medical condition (asthma/diabetes)?	<input type="checkbox"/>	<input type="checkbox"/>	1. Do you have a history of recurrent or persistent rashes, pressure sores, herpes, or other skin infections?	<input type="checkbox"/>	<input type="checkbox"/>
CARDIAC RISK:			2. Have you ever been diagnosed or treated for a MRSA infection?	<input type="checkbox"/>	<input type="checkbox"/>
1. Has any relative died of a heart condition suddenly before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	3. History of Mono (EBV) in the last 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you or your relatives have a history of:			4. History of recurrent unexplained fevers, or chronic coughing?	<input type="checkbox"/>	<input type="checkbox"/>
a. Heart muscle disease such as hypertrophic cardiomyopathy?	<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"/>
b. Arrhythmia, irregular rhythm, pacemaker WPW (Wolf Parkinson White), Long QT syndrome or other cardiac problem?	<input type="checkbox"/>	<input type="checkbox"/>	6. History of Hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>
c. Marfan Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	7. History of HIV?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	ORTHOPEDIC RISK:		
4. Have you ever had chest pain during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	1. Have you ever broken any bones?	<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"/>	2. History of neck or back injury?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have a history of high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	3. History of chronic back or neck pain?	<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"/>	4. History of ankle, knee, hip injury?	<input type="checkbox"/>	<input type="checkbox"/>
8. History of unexplained dizziness with exercise?	<input type="checkbox"/>	<input type="checkbox"/>	5. History of wrist, elbow, shoulder injury?	<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"/>	6. Do you have any artificial limbs or prosthetic devices (false teeth)?	<input type="checkbox"/>	<input type="checkbox"/>
10. History of congenital heart disease?	<input type="checkbox"/>	<input type="checkbox"/>	OTHER PERTINENT QUESTIONS:		
11. History of Carditis or Kawasaki disease?	<input type="checkbox"/>	<input type="checkbox"/>	1. Are you taking any prescription or nonprescription (over the counter) medicines or pills?	<input type="checkbox"/>	<input type="checkbox"/>
RESPIRATORY RISK:			2. Are you taking supplements or medications to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
1. History of cough, wheezing, or difficulty breathing during or after exercise?	<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"/>
2. Have you ever used an inhaler or taken asthma medication?	<input type="checkbox"/>	<input type="checkbox"/>	4. Are you trying to gain or lose weight?	<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"/>	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"/>
4. Have you ever been told by a doctor that you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>	6. History of bleeding or clotting disorder?	<input type="checkbox"/>	<input type="checkbox"/>
5. History of fractured ribs in the last 6 weeks?	<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"/>
NEUROLOGICAL RISK:			8. History of surgery?	<input type="checkbox"/>	<input type="checkbox"/>
1. History of head or neck injury, or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	9. History of enlarged liver or spleen?	<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"/>	10. History of sickle cell disease/trait?	<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"/>	11. History of Hypoglycemia (low blood sugar)?	<input type="checkbox"/>	<input type="checkbox"/>
4. History of seizures?	<input type="checkbox"/>	<input type="checkbox"/>	Any medical changes since your last physical ?	<input type="checkbox"/>	<input type="checkbox"/>
5. History of headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>	FEMALES OLDER THAN 16 (OPTIONAL)		
6. Do you have a history of any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had no periods?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	Have you gone more than 90 days without a period in the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
8. History of neck instability (i.e. Atlantoaxial Instability)	<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 _____

SPORTS PHYSICAL SCHOOL FORM

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

Signature of Parent/Guardian: _____ Medical Insurance Co. _____

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 \leq 25dbcls (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, and Tetanus and Pertussis

Received Varicella Vaccine/ or Varicella illness after 1 yr. of Age Date of Last Tdap: _____

Up to date (See Attached Vaccine Documentation) Not up to Date, Vaccines Needed: _____

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: _____ OFFICE STAMP:

- 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):

Recommendations: _____

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

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

Based on recommendations developed by the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopedic Society for Sports Medicine and American Osteopathic Academy for Sports Medicine. Rev. Dec 2010.