********** ATHLETIC PHYSICAL EXAMINATION FORM **********

ATHLETIC PHYSICALS CAN BE SCHEDULED AFTER MAY 1ST FOR THE UPCOMING SCHOOL YEAR

A physical examination is required prior to the participation of a student in supervised athletic activities.
When completed, please return it to the ***Office of the School Nurse or the Athletic Coach.***

Name of Student (Last / First / Middle) Date of Birth Age Grade

Name of Father/Guardian Address (Street/City/Zip) Home Phone Cell Phone Business Phone

Name of Mother/Guardian Address (Street/City/Zip) Home Phone Cell Phone Business Phone

Name of Person to Contact in case of Emergencies (other than the above) Address (Street/City/Zip) Home Phone Cell Phone Business Phone Relationship

Health Insurance **YES /NO** _____ _____ _____
Insurance Company Policy Number Family Medical Provider/City/Business Phone Family Medical Provider/City/Business Phone

Height _____ Heart _____ BP _____ Pulse _____ Liver _____ Spleen _____ Musculoskeletal _____

Weight _____ Hearing **Right** _____ **Left** ____ Ears _____ Lungs _____ Neck _____ Hernia _____ Neurological _____

BMI _____ Vision **R 20/** ____ **L 20/** ____ Eyes _____ Head _____ Skin _____ Genitalia _____ Scoliosis _____

Laboratory _____ Urinalysis_____ Immunization Updates (Type / Date) _____

Concussion(s) / Recent Trauma and/or Injury (include dates) _____

Comments: _____

"I certify that I have on this date examined this student and that, on the basis of the examination requested by the school authorities and the student's medical history furnished to me, I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities, EXCEPT THOSE CROSSED OUT BELOW."

Softball Golf Plays Basketball Track Cross Country Football Speech Volleyball Music Wrestling Cheer Dance

*Medical Provider's Signature*_____ *Date of Examination*_____ *Name of Clinic*_____

HEALTH HISTORY (*Must be complete prior to physical appointment)*

PLEASE CIRCLE	GENERAL QUESTIONS	YES / NO		PLEASE CIRCLE	MEDICAL QUESTIONS
YES / NO	Have you ever had your participation in sports denied or restricted?	YES / NO	Have you been diagnosed with Covid – 19?	YES / NO	Do you or anyone in your family have ASTHMA?
YES / NO	Have you ever had surgery?	YES / NO	Do you have a history of headaches?	YES / NO	Do you cough, wheeze, or have difficulty breathing during or after exercise?
YES / NO	Have you ever spent the night in a hospital?	YES / NO	Do you have a seizure disorder?	YES / NO	Do you use an inhaler?
Circle all that apply	Do you have any ongoing medical conditions? ADHD / Diabetes/ Other	YES / NO	Do you take any seizure medications? List: _____	PLEASE CIRCLE	BONE & JOINT QUESTIONS
YES / NO	Do you take any medications for this? List: _____	Circle all that apply	Have you ever had an injury to a bone / muscle / ligament / or tendon?	YES / NO	Have you had Mono within the last month?
YES / NO	Have you ever had an unexplained seizure?	YES / NO	Have you ever had broken or fractured bones or dislocated joints?	YES / NO	Do you have pain or bulge in the groin area?
YES / NO	Have you ever felt like passing out during or after exercise?	Circle all that apply	Have you ever had an injury that required ax-ray / MRI / CT scan / injection / therapy / brace / cast or crutches?	Circle all that apply	Have you ever had any of these skin problems? herpes / MRSA /rash or sore that won't heal?
YES / NO	Have you had discomfort, pain, tightness, or pressure in your chest during exercise?	YES / NO	Have you ever had a stress fracture?	YES / NO	Have you ever become ill after exercising in the heat?
YES / NO	Does your heart race, skip beats or have irregular beats during exercise?	YES / NO	Do you regularly use a brace, orthotics or other assistive device?	YES / NO	Do you get frequent muscle cramps when exercising?
YES / NO	Has a provider eve ordered a test for your heart?	YES / NO	Do you have a bone, muscle or joint injury that bothers you?	YES / NO	Have you ever had numbness, tingling, or weakness or been unable to move after being hit or falling?
YES / NO	Do you get lightheaded or feel shorter of breath than expected during exercise?	YES / NO	Do any of your joints become painful, swollen, feel warm or look red?	Circle all that apply	Have you ever had any eye injuries or problems with your eyes or vision?
Circle all that apply	Has a provider ever told you that you have a heart problem? Murmur / high blood pressure / high cholesterol. infection	YES / NO	Do you have a history of juvenile arthritis or connective tissue disease?	YES / NO	Do you wear glasses / contacts / protective eye wear?
Circle all that apply	Does anyone in your family have a pacemaker / implanted defibrillator or had an unexpected death before age 50?		FEMALES ONLY	YES / NO	Do you have any concerns you would like to discuss with a provider?
Circle all that apply	Has anyone in your family had unexplained fainting / seizures / or near drowning?		What was your age when you had your first menstrual period? _____	YES / NO	Are you or have you been sexually active?
Circle all that apply	Do you use Alcohol / Smoke / Vape / Chew Tobacco?	YES / NO	Are your periods regular? How many days do your periods last? _____	YES / NO	If yes: are you using proper protection?
YES / NO	Are you driving with a license or school permit?	YES / NO	Do you have any concerns regarding your menstrual cycle?	YES / NO	Do you worry about or are you trying to gain or lose weight?
YES / NO	Do you wear your seatbelt?				Have you ever had a head injury or concussion?

I hereby state that to the best of my knowledge, my answers to the above questions are complete and correct. I hereby give permission for the release of this form to the school for the purpose of participation in athletics and activities.

Parent/Legal Guardian Signature: _____ Date: _____