STUDENT ATHLETIC PHYSICAL EXAMINATION

Name: ______________________________ School: ____________________

Age: ______ Date of Birth: ___-___-___ Sex: M/F Sport: ________________ Date: ____-____

Height:______ Weight ______ Family Physician:__________________ Date of Last Physical ____

List all medications you are currently taking: ______________________________

List foods/drinks you are allergic to: ____________ List medications you are allergic to: __________

Medical History

1. Have you ever had a concussion? Yes / No
2. Have you ever been knocked out? Yes / No
3. Have you ever injured your neck? Yes / No
4. Have you ever had an allergic reaction to an insect bite? Yes / No
5. Has your guardian or a physician ever told you that you have a heart murmur? Yes / No
6. Do you experience frequent chest pains? Yes / No
7. Have you fainted in the last 2 years? Yes / No
8. Do either of your parents have/had heart disease? Yes / No
9. Has a physician or guardian told you that you have asthma? Yes / No
10. Has a physician told you are a hemophiliac? Yes / No
11. Have you been hospitalized for any reason in the last year? Yes / No
    (give details): ______________________________
    ____
12. Has your guardian or physician told you have epilepsy? Yes / No
13. Has your guardian or physician told you that you had a hernia? Yes / No
14. Do you have both of your kidneys? Yes / No
15. Have you had your spleen removed? Yes / No

(to be completed by a physician)

Orthopaedic/Neurological	Heart/Lungs Blood Pressure: Resting HR: bpm
Abdomen	Eyes, Ears, Nose, Throat

Physician's Recommendations: ______________________________
____

Above athlete *MAY/MAY NOT* participate in athletics:
______________________Date________
(physician's signature)