

BEAR CREEK SPORT PHYSICAL

Name: _____ Gender: M F Date of Birth: ____/____/____

Parent Name: _____ Phone number: _____

Street address: _____

City: _____ State: _____ Zip Code: _____ Grade: FR. SO. JR. SR.

Please indicate MEDICAL ALERTS such as allergic reactions, contact lenses, etc.:

Medical History:

Athletes and parents: This health record is a critical element in the determination of an athlete's risk of injury in sports. Please take the time to read and answer all questions before seeing a physician for the athlete's physical examination.

- | | |
|--|--------|
| 1. Has anyone in the athlete's family (grandparents, mother, father, brother, sister, aunt, uncle) died suddenly before age 50? | YES NO |
| 2. Has the athlete ever stopped exercising because of dizziness or passed out during exercise? | YES NO |
| 3. Does the athlete have asthma (wheezing), hay fever, or coughing spells after exercise? | YES NO |
| 4. Has the athlete ever had a broken bone, had to wear a cast, or had an injury to any joint? | YES NO |
| 5. Does the athlete have a history of concussion (getting knocked out)? | YES NO |
| 6. Has the athlete ever suffered a heat-related illness (heat stroke)? | YES NO |
| 7. Does the athlete have a chronic illness or see a doctor regularly for any particular problem? | YES NO |
| 8. Does the athlete take any medication(s)? | YES NO |
| 9. Is the athlete allergic to any medications or bee stings? | YES NO |
| 10. Has the athlete had an injury in the last year that caused the athlete to miss 3 or more consecutive days of practice or competition? | YES NO |
| 11. Has the athlete had surgery or been hospitalized in the past year? | YES NO |
| 12. Has the athlete missed more than 5 consecutive days of participation in usual activities because of illness, or has the athlete had a medical illness diagnosed that has not been resolved in the past year? | YES NO |
| 13. Are you, the athlete, worried about any problem or condition at this time? | YES NO |

Please give details on any "YES" answer from the above health history-

STUDENT NAME: _____ **Parent Name:** _____

PHYSICAL EXAM – TO BE COMPLETED BY PHYSICIAN

Height _____ Weight _____ Pulse _____ Blood Pressure _____

	Normal	Abnormal Findings
Eyes		
Ears, Nose, Throat		
Mouth, Teeth		
Heart		
Chest and Lungs		
Abdomen		
Testicles/ Genitalia		
Neck		
Spine		
Shoulders		
Arms/Hands		
Hips		
Thighs		
Knees		
Ankles		
Feet		
CLEARED FOR ATHLETICS		

Please print / Stamp

Physician's Name _____

Street Address _____

Telephone: _____

Physician Signature _____ **Date** _____

PARTICIPATION RESTRICTIONS: _____
