

Merced City School District

SPORTS PHYSICAL EXAMINATION FORM

PART 1 (TO BE COMPLETED BY A PARENT OR LEGAL GUARDIAN)

LAST NAME		FIRST NAME		GRADE	
BIRTHDATE	FALL SPORT	WINTER SPORT	SPRING SPORT	STUDENT ID NUMBER	

HEALTH HISTORY (Must be Completed Prior to the Examination)

	Yes	No	Has this student had any:		Yes	No	Does this student:
1.	☐	☐	Chronic or recurrent illness?	16.	☐	☐	Wear eyeglasses or contact lenses?
2.	☐	☐	Illness lasting over 1 week?	17.	☐	☐	Wear dental bridges, braces or plates?
3.	☐	☐	Hospitalizations or Surgery?	18.	☐	☐	Take any medications? (List below):
4.	☐	☐	Nervous, psychiatric, or neurologic condition?		Yes	No	Is there any history of:
5.	☐	☐	Loss or nonfunctioning of organs (eye, kidney, liver, testicle) or glands?	19.	☐	☐	Injuries requiring medical care or treatment?
6.	☐	☐	Allergies (medicines, insect bites, food)?	20.	☐	☐	Neck or back pain or injury?
7.	☐	☐	Problems with heart or blood pressure?	21.	☐	☐	Knee pain or injury?
8.	☐	☐	Chest pain or severe shortness of breath with exercise?	22.	☐	☐	Shoulder or elbow pain or injury?
9.	☐	☐	Dizziness or fainting with exercise?	23.	☐	☐	Ankle pain or injury?
10.	☐	☐	Fainting, bad headaches or convulsions?	24.	☐	☐	Other joint pain or injury?
11.	☐	☐	Concussion or loss of consciousness?	25.	☐	☐	Broken bones (fractures)?
12.	☐	☐	Heat exhaustion, heatstroke, or other problems with heat?		Yes	No	Further history:
13.	☐	☐	Racing heart, skipped, irregular heartbeats, or heart murmur?	26.	☐	☐	Birth defects (corrected or not)?
14.	☐	☐	Seizures?	27.	☐	☐	Death of parent or grandparent less than 40 years of age due to medical cause or condition?
15.	☐	☐	Severe or repeated instances of muscle cramps?	28.	☐	☐	Parent or grandparent requiring treatment for heart condition less than 50 years of age
Date of last known tetanus (lockjaw) shot: _____				29.	☐	☐	Been seen by a physician on an emergency or urgent basis in the last 12-months?
Date of last complete physical examination: _____							

Explain all "YES" answers here along with any other fact or circumstance that should be disclosed prior to the examination (use reverse of form if needed):

PARENT/GUARDIAN'S AUTHORIZATION: I authorize a physician or duly authorized and supervised physician's assistant or nurse practitioner to perform a Sports Physical Evaluation on the student. The information set forth above is complete and accurate and I know of no reason why the student cannot fully and safely participate in the listed sports. I understand that this is solely a screening examination and that the absence of any health conditions or concerns listed below does not mean that student is free from actual or potential harmful health conditions that may cause the student injury or death while participating in sports. Any question or concern I may have regarding the student's health or safety will be referred to our personal physician or health care provider for review and evaluation.

PRINT NAME OF PARENT OR GUARDIAN		SIGNATURE OF PARENT OR GUARDIAN	
ADDRESS		WORK PHONE	HOME PHONE
		DATE	
REGULAR PHYSICIAN'S NAME		OFFICE PHONE	

PART 2 (TO BE COMPLETED BY THE EXAMINING PHYSICIAN/PHYSICIAN'S ASSISTANT/NURSE PRACTITIONER)

	NORMAL	ABNORMAL (Describe)	
Eyes/Ears/Nose/Throat			Height:
Skin			Weight:
Heart			Pulse: After Ex:
Abdomen			BP:
Genital/hernia (males)			Recommendation: ☐ Unlimited participation ☐ Limited participation/specific sports, events or activities
Musculoskeletal:			
a. Neck/Spine/Shoulders/Back			
b. Arms/Hands/Fingers			

c. Hips/Thighs/Knees/Legs			☐ Clearance withheld pending further testing/evaluation ☐ No athletic participation <i>One of the above <u>MUST</u> be checked.</i>
d. Feet/Ankles			
Neurologic Screening Exam (NSE)			
Comments:			
PRINT NAME OF PHYSICIAN (M.D., D.O., P.A., or N.P. only)		PHYSICIAN'S SIGNATURE	DATE