



# SPORTS PHYSICAL EXAM FORM

LINK TO SPORTS NET



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

|            |       |                   |        |
|------------|-------|-------------------|--------|
| Last Name: |       | First Name:       |        |
| DOB:       | SPORT | Student ID Number | Grade: |

### Part 1 – Health History (Must be completed by Parent/Guardian Prior to the Examination)

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| <b>YES</b> <b>NO</b> <u>Has the student had:</u><br><input type="checkbox"/> <input type="checkbox"/> Chronic or recurrent illness?<br><input type="checkbox"/> <input type="checkbox"/> Illness lasting over 1 week?<br><input type="checkbox"/> <input type="checkbox"/> Hospitalizations or Surgeries?<br><input type="checkbox"/> <input type="checkbox"/> Nervous, psychiatric, or neuralgic condition?<br><input type="checkbox"/> <input type="checkbox"/> Loss or nonfunctioning of organs (eye, kidney, liver, testicle) or glands?<br><input type="checkbox"/> <input type="checkbox"/> Allergies (medicine, insect bites, food)?<br><input type="checkbox"/> <input type="checkbox"/> Problems with heart or blood pressure?<br><input type="checkbox"/> <input type="checkbox"/> Chest Pain or significant or severe shortness of breath during or after exercise?<br><input type="checkbox"/> <input type="checkbox"/> Dizziness or fainting with exercise?<br><input type="checkbox"/> <input type="checkbox"/> Fainting, bad headaches or convulsions?<br><input type="checkbox"/> <input type="checkbox"/> Potential concussion or loss of consciousness?<br><input type="checkbox"/> <input type="checkbox"/> Heat exhaustion, heatstroke, or other problems managing or responding to heat?<br><input type="checkbox"/> <input type="checkbox"/> Racing heartbeat, skipped or irregular heartbeats, or heart murmur?<br><input type="checkbox"/> <input type="checkbox"/> Seizures or seizure disorders?<br><input type="checkbox"/> <input type="checkbox"/> Sever or repeated instances of muscle cramps?<br><u>Explain all "Yes" answers:</u> | <b>YES</b> <b>NO</b> <u>Has the student had:</u><br><input type="checkbox"/> <input type="checkbox"/> Injuries requiring medical care or treatment?<br><input type="checkbox"/> <input type="checkbox"/> Neck or back pain or injury?<br><input type="checkbox"/> <input type="checkbox"/> Knee pain or injury?<br><input type="checkbox"/> <input type="checkbox"/> Shoulder or elbow pain or injury?<br><input type="checkbox"/> <input type="checkbox"/> Ankle pain or injury?<br><input type="checkbox"/> <input type="checkbox"/> Other joint pain or injury?<br><input type="checkbox"/> <input type="checkbox"/> Broken bones (fracture)?<br><b>YES</b> <b>NO</b> <u>Does this student presently:</u><br><input type="checkbox"/> <input type="checkbox"/> Wear eyeglass or contact lenses?<br><input type="checkbox"/> <input type="checkbox"/> Wear dental bridges, braces or plates?<br><input type="checkbox"/> <input type="checkbox"/> Take any medications? (list below)<br><u>Further History:</u><br><input type="checkbox"/> <input type="checkbox"/> Birth defects (corrected or not)<br><input type="checkbox"/> <input type="checkbox"/> Death of a parent or grandparent less than 40 years of age due to medical cause or condition?<br><input type="checkbox"/> <input type="checkbox"/> Parent or grandparent requiring treatment for heart condition less than 50 years of age?<br><input type="checkbox"/> <input type="checkbox"/> Been seen by a physician on an emergency or urgent basis in the last 12 months?<br><u>Explain all "Yes" answers:</u> |
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|                                  |                                             |
|----------------------------------|---------------------------------------------|
| Date of last known tetanus shot: | Date of last complete physical examination: |
|----------------------------------|---------------------------------------------|

**PARENT/GUARDIAN'S AUTHORIZATION:** I authorize the health care provider to perform a Sports Physical Evaluation on the student. The information set forth above is complete and accurate. I presently know of no reason why the student cannot fully and safely participate in the listed sports. For Sports Physical Evaluations that may be performed by District volunteers, I understand the evaluation is a screening evaluation only, and that I must address all health care concerns with the Student's personal physician or health care provider.

|                                  |                                 |      |
|----------------------------------|---------------------------------|------|
| PRINT NAME OF PARENT OR GUARDIAN | SIGNATURE OF PARENT OR GUARDIAN |      |
| ADDRESS                          | HOME PHONE                      | DATE |
| REGULAR PHYSICIANS NAME          | OFFICE PHONE                    |      |

## PART 2 – MEDICAL EVALUATION (TO BE COMPLETED BY THE EXAMING HEALTH CARE PROVIDER)

This evaluation Can Only be Performed by Medical Doctor(MD), Doctors of Osteopathy(DO), Physician's Assistant (P.A.), and Nurse Practitioners (N.P.)

|                                  | NORMAL | ABNORMAL (Describe) | (May be contained on Provider's Form)                                                  |
|----------------------------------|--------|---------------------|----------------------------------------------------------------------------------------|
| Eyes/Ears/Nose/Throat            |        |                     | Height: Weight:                                                                        |
| Heart, lungs, pulmonary function |        |                     | Pulse: After Ex:                                                                       |
| Abdomen, genital/hernia (males)  |        |                     | BP:                                                                                    |
| Skin and Musculoskeletal:        |        |                     | <b>Recommendation:</b>                                                                 |
| a. Neck/Spine/Shoulders/Back     |        |                     | <input type="checkbox"/> Unlimited participation                                       |
| b. Arms/Hands/Fingers            |        |                     | <input type="checkbox"/> Limited participation/specific sports, events, or activities. |
| c. Hips/Thighs/Knees/Legs        |        |                     | <input type="checkbox"/> Clearance withheld pending further Testing/evaluation         |
| d. Feet/Ankles                   |        |                     | <input type="checkbox"/> No athletic participation                                     |
| Neurologic screening Exam (NSE)  |        |                     | <i>One of the above MUST be checked.</i>                                               |
| Concussion Screening Evaluation  |        |                     |                                                                                        |

|                                      |                      |      |
|--------------------------------------|----------------------|------|
| (Only if needed based on above info) |                      |      |
| PRINT NAME OF PROVIDER               | PROVIDER'S SIGNATURE | DATE |
| COMMENTS:                            |                      |      |