Sports Pre-Participation Physical Form

Name: _____ *Date of Birth:* _____

Athletes and parents: Please read and circle the correct responses before seeing your physician.

1. Has anyone in the athlete's family (grandparents, parents, siblings) died suddenly before age 50?	YES	NO	DON'T KNOW
2. Has athlete ever stopped exercising due to dizziness, chest pain, or passed out during exercise?	YES	NO	DON'T KNOW
3. Does the athlete have asthma (wheezing), hay fever or coughing spells after exercise?	YES	NO	DON'T KNOW
4. Has the athlete ever had a broken bone, had to wear a cast, or had an injury to any joint?	YES	NO	DON'T KNOW
5. Does the athlete have a history of a concussion?	YES	NO	DON'T KNOW
6. Has the athlete ever suffered a heat-related illness (such as heat stroke or heat exhaustion)?	YES	NO	DON'T KNOW
7. Does the athlete have a chronic illness or see a doctor regularly for any particular problem?	YES	NO	DON'T KNOW
8. Does the athlete take any medication(s)? *List:*	YES	NO	DON'T KNOW
9. Is the athlete allergic to any medications or bee stings? *Allergies:*	YES	NO	DON'T KNOW
10. Does the athlete have only one of any paired organ? (eyes, kidneys, testicles, ovaries, etc.)	YES	NO	DON'T KNOW
11. Has the athlete had an injury in the last year that caused the athlete to miss three or more consecutive days of practice or competition?	YES	NO	DON'T KNOW
12. Has the athlete had surgery or been hospitalized in the past year?	YES	NO	DON'T KNOW
13. Has the athlete missed more than five consecutive days of participation in usual activities because of an illness, or does the athlete have a current medical illness?	YES	NO	DON'T KNOW
14. Are you, the athlete, worried about any problem or condition at this time?	YES	NO	DON'T KNOW
15. Does the athlete have diabetes?	YES	NO	DON'T KNOW

***Please give details on any "YES" answer from the above health history:** _____

_____

PHYSICAL EXAM: TO BE COMPLETED BY PHYSICIAN: **Date of LAST TETANUS BOOSTER:** _____

Height _____ Weight _____ Pulse _____ Blood Pressure _____

Vision: R _____/_____ uncorrected R _____/_____ corrected L _____/_____ uncorrected L _____/_____ corrected

	NORMAL	ABNORMAL (explain)	INITIALS
Eyes			
Ears, Nose, Throat, Teeth			
Neck			
Cardiovascular			
Chest & Lungs			
Abdomen			
Skin			
Genitalia/Hernia			
Spine			
Shoulders/Arms/Hands			
Hips/Thighs/Knees			
Ankles/feet			
Neurologic			

I certify that I have examined this athlete and found him/her medically qualified to participate in sports. I also certify that I am a licensed medical physician, physician's assistant, or family nurse practitioner in the United States.

Physician's Signature: _____ Date: _____

Physician Name (print): _____ Phone: _____ Fax: _____

PARTICIPATION RESTRICTIONS: _____