

**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

PART 1 -- HEALTH HISTORY (Must be Completed by Parent/Guardian Prior to the Examination)

Yes	No	Has this student had:	Yes	No	
☐	☐	Chronic or recurrent illness?	☐	☐	Seizures or seizure disorders?
☐	☐	Illness lasting overweek?	☐	☐	Severe or repeated instances of muscle cramps?
☐	☐	Hospitalizations or Surgeries?	☐	☐	Injuries requiring medical care or treatment?
☐	☐	Nervous, psychiatric, or neurologic condition?	☐	☐	Neck or back pain or injury?
☐	☐	Loss or nonfunctioning of organs (eye, kidney, liver, testicle) or glands?	☐	☐	Knee pain or injury?
☐	☐	Allergies (medicines, insect bites, food)?	☐	☐	Shoulder or elbow pain or injury?
☐	☐	Problems with heart or blood pressure?	☐	☐	Ankle pain or injury?
☐	☐	Chest pain or significant or severe shortness of breath during or after exercise?	☐	☐	Other joint pain or injury?
☐	☐	Headaches, dizziness or fainting with exercise?	☐	☐	Broken bones (fractures)?
☐	☐	Fainting, bad headaches or convulsions?	☐	☐	Does this student presently:
☐	☐	Potential head injury, concussion or loss of consciousness?	☐	☐	Wear eyeglasses or contact lenses?
☐	☐	A hit or blow to the head causing confusion, prolonged headache or memory problems?	☐	☐	Wear dental bridges, braces or plates?
☐	☐	Numbness, tingling, weakness or inability to move your arms or legs after being hit or falling?	☐	☐	Take any medications? (List below):
☐	☐	History of migraine headaches or sleep disturbances?	☐	☐	Further history:
☐	☐	Heat exhaustion, heatstroke, or other problems managing or responding to heat?	☐	☐	Birth defects (corrected or not)?
☐	☐	Racing heartbeat, skipped or irregular heartbeats, or heart murmur?	☐	☐	Death of a parent or grandparent less than 40 years of age due to medical cause or condition?
			☐	☐	Parent or grandparent requiring treatment for heart condition less than 50 years of age?
			☐	☐	Been seen by a physician on an emergency or urgent basis in the last 12-months?

Date of last known tetanus (lockjaw) shot: _____ Date of last complete physical examination: _____

Explain all "YES" answers. Describe any other fact that should be disclosed prior to the examination (use reverse of form if needed):

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	WORK PHONE	HOME PHONE	DATE
REGULAR PHYSICIAN'S NAME	OFFICE PHONE	PROVIDER CLINIC OR ORGANIZATION	

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

This Evaluation Can Only be Performed by Medical Doctors (MDs), Doctors of Osteopathy (DOs), Physician's Assistants (P.A.s), and Nurse Practitioners (N.P.s)

	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:			Recommendation:
a. Neck/Spine/Shoulders/Back			☐ Unlimited participation
b. Arms/Hands/Fingers			☐ Limited participation/specific sports, events or activities
c. Hips/Thighs/Knees/Legs			☐ Clearance withheld pending further testing/evaluation
d. Feet/Ankles			☐ No athletic participation
Neurologic Screening Exam (NSE)/			One of the above MUST be checked.
Concussion Screening Evaluation (only if needed based on above info.)			
Comments:			PHYSICIAN STAMP
PRINT NAME OF PHYSICIAN	PHYSICIAN'S SIGNATURE		DATE