SPORTS PHYSICAL FORM

PART A: To Be Filled Out by the Athlete

Name: _____ School: _____ Grade: _____

Address: _____ Phone Number: _____

Date of Birth: _____ Age: _____ Name of Parents: _____

Sport (s): _____ Position (s): _____ Coach (es): _____

Please Check if you have had any problems in the following areas:

____ Concussion, "Knocked Out"	____ Neck Injury	____ Back Injury, Pain
____ Shoulder Injury	____ Arm, Elbow, Hand Injury	____ Knee Injury, Popping
____ Groin, Thigh, Leg Injury	____ Ankle, Foot Injury	____ Swelling, Pain, Locking or giving way

Yes	No	
____	____	Have any members of your family under the age of 40 had a "heart attack" or sudden death?
____	____	Have you ever had chest pain while exercising or passed out?
____	____	Do you have coughing, wheezing, or severe shortness of breath with exercise?
____	____	Are you taking any medication?
____	____	Do you have any allergies?
____	____	Have you had ear problems or difficulty hearing?
____	____	Do you wear glasses or contact lenses?
____	____	Have you ever had any discomfort in your groin (hernia)?
____	____	Have you ever had any illness or injuries that required hospitalization, surgery, or repeated visits to the doctor?

PART B: To Be Filled Out by the Physician

Height: _____ Weight: _____ Blood Pressure: _____

Eye: R 20/ _____ L 20/ _____ Ears: _____ Skin: _____ Lungs: _____

Heart: _____ Abdomen: _____ Neurologic: _____ Urinalysis (if indicated): _____

MEDICAL FINDINGS	RECOMMENDATIONS
____	____ Follow up with athlete's physician
	____ Other

MUSCULOSKELETAL	RECOMMENDATIONS
____ Neck Weakness	____ Strengthening Exercises, Neck
	____ Neck Roll (equipment)
____ Shoulder Weakness	____ Strengthening Exercises, Shoulder
____ Shoulder Injury	
____ Scoliosis	
____ Tight Hamstring	____ Hamstring Stretching
____ Tight Groin Muscle	____ Groin Stretching
____ Worn Knee Cap	____ Quadriceps Strengthening
____ Knee Injury; ligament, cartilage	____ Knee Brace
____ Tight Achilles Tendon	____ Achilles Stretches
____ Weak Ankles	____ Strengthening Exercises, Ankles
	____ Tape or Wrap Ankles
	____ Referral to Orthopedist
	____ Referral to Athletic Trainer
	____ Other

I certify on this date I have examined and find him/her physically able to compete in supervised activities with restrictions as noted:

Restrictions: _____

PHYSICIAN'S SIGNATURE: _____ DATE: _____

PHYSICIAN'S NAME (Please print) _____

White – School/Sponsor Yellow – Parent Pink – Doctor Goldenrod – School Nurse 5/28/03