Adolescent / Sports Physical Form

_________________________________ Date of Birth: ____________ Sex: ☐ Male ☐ Female
Last Name **First Name** **MI** **Month/Day/Year**

School: ______________________________________ Grade: __________

Home Address: ______________________________________ Phone: ____________________

In case of emergency, notify: Name ______________________ Phone: ____________________

Section A. For those participating in school sports only:

This application to compete in interscholastic athletics is entirely voluntary on my part and is made with the understanding that I have not violated any of the eligibility rules and regulations of the State Association.

_________________________________ ____________________
Signature of Student **Date**

Parent or Guardian's Permission and Release

I hereby give my consent for the above-named student to represent his or her school in athletic activities except those indicated on this form by the examining physician, provided that such athletic activities are approved by the State Association. I also give my consent for the student to accompany the school team on any of its local or out-of-town trips.

The ______________ Board of Education has no responsibility to provide first aid at any of the games and the parent or guardian understands that the risk of injury is assumed by the student and parent when they sign this form. However, in the event physicians, physical therapists, physician's assistants, nurses, or other persons trained in the rendering of first aid are available, as volunteers or otherwise and render aid to any student injured during the course of any such activities or travel, then the parents do hereby release and forever discharge such persons and the ______________ Board of Education from any liability arising out of any first aid or immediate treatment of injuries.

_________________________________ _________________________________
Typed or printed Name of Parent or Guardian **Signature of Parent or Guardian**

_________________________________ ______________ ______________
Address **Phone** **Date**

Section B. – Health History - To be completed by all students and their parent(s) prior to examination:

Date of last tetanus (required every 10 years): ______________ Date of first MMR (required): ______________

Date of second MMR (required): ______________ Dates of Hepatitis B series (recommended): ______________

The following are questions to be answered by checking the appropriate space under YES or NO.

	Yes	No
Have you been under a doctor's care or hospitalized in the past 12 months?	[ ]	[ ]
Have you ever had any type of surgery?	[ ]	[ ]
Do you want to talk about a health problem, injury, or emotional problem?	[ ]	[ ]
Has anyone in your immediate family, under age 50:		
ever had heart trouble?	[ ]	[ ]
died suddenly?	[ ]	[ ]
Have you ever had or do you now have:		
Brain concussion (head injury)	[ ]	[ ]
Tendency to lose consciousness (faint)	[ ]	[ ]
Convulsions or epilepsy	[ ]	[ ]
Neck or back injury	[ ]	[ ]
Very bad vision in one eye	[ ]	[ ]
To wear glasses or contact lenses	[ ]	[ ]
Hearing loss	[ ]	[ ]
Perforated eardrum	[ ]	[ ]
Discharge from ear (s)	[ ]	[ ]
Hernia	[ ]	[ ]
Kidney problems	[ ]	[ ]
Loss of function of testicle (boys)	[ ]	[ ]
Menstrual problems (girls)	[ ]	[ ]
Age of menstruation ______		
Bone fractures	[ ]	[ ]
Joint dislocation or other problems	[ ]	[ ]
Foot or ankle problems	[ ]	[ ]
Diabetes	[ ]	[ ]

	Yes	No
Weight problems	[ ]	[ ]
Asthma	[ ]	[ ]
Hives or rash	[ ]	[ ]
Bee-sting allergy	[ ]	[ ]
Medicine reactions	[ ]	[ ]
Heart trouble or murmur	[ ]	[ ]
High blood pressure	[ ]	[ ]
Chest pain with exercise	[ ]	[ ]
Dizziness or faintness with exercise	[ ]	[ ]
Do you:		
Smoke or chew tobacco?	[ ]	[ ]
Take any medicine regularly?	[ ]	[ ]
If YES, name of medication ________		
Take any medicine for emergency use?	[ ]	[ ]
If YES, name of medication________		
Use alcohol?	[ ]	[ ]
Use other drugs?	[ ]	[ ]
Have you ever been told to give up sports because of a health problem?	[ ]	[ ]

If you have answered YES to any of the above questions, please explain below:

____

____

____

Section C. – Physical Examination (Required Yearly) – To be completed by health care professional.

Date of Exam ______________

Height ________ Weight ________ Pulse ________ BP _____/_____

Vision: Left 20/_____ Right 20/_____ ☐ Without corrective lenses ☐ With corrective lenses

	Normal	Abn.	Not Done	Comments
Skin				
Eyes				
Ears/nose/throat				
Mouth and teeth				
Neck				
Spine				
Chest and lungs				
Cardiovascular				
Abdomen				
Genitalia-hernia				
Sexual Maturity				
Lymphatics				
Neurological				
Upper extr.				
Hip/thigh/knees				
Ankles and feet				

Healthcare Professional's Recommendations

☐ **No history or physical findings on this exam would prohibit this student from participating in sports.**

☐ **This student should have the following health problems evaluated or treated before participation recommendations can be made:**

____

____

☐ **This student has health problems that prohibit him or her from participating in the requested sports:**

____

____

***however*, this student can participate in the following sports:**

____

____

______________________________**,MD/DO/PA/NP** **Date**______________