

**Sports Physical**

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician

Signature \_\_\_\_\_

Restrictions \_\_\_\_\_

**HISTORICAL DATA**

Name (last, first, middle initial) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sports Fall \_\_\_\_\_ Spring \_\_\_\_\_

Winter \_\_\_\_\_ School Year 20\_\_\_\_\_

Class: \_\_\_\_ 7<sup>th</sup> Grade \_\_\_\_ 8<sup>th</sup> Grade \_\_\_\_ Freshman \_\_\_\_ Sophomore \_\_\_\_ Junior \_\_\_\_ Senior

Parent(s) Name(s) \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Family Physician \_\_\_\_\_

**PAST MEDICAL HISTORY** Please list all that apply

Current Medications \_\_\_\_\_

Allergies (drug, food, bee sting, etc) \_\_\_\_\_

Significant Past/ Present medical Problems \_\_\_\_\_

Operations/Hospitalizations \_\_\_\_\_

Significant Family Medical Problems \_\_\_\_\_

Deformities (kidney, blindness, heart/back problems, etc.) \_\_\_\_\_

Check if you have the following: \_\_\_\_Glasses \_\_\_\_Contact Lenses \_\_\_\_ Braces \_\_\_\_Bridges

Check if you have/have had the following: \_\_\_\_Fainting or dizziness while exercising  
\_\_\_\_Head injury or loss of concentration

Date of last: Tetanus shot \_\_\_\_\_ Dental exam \_\_\_\_\_ Eye Exam \_\_\_\_\_

**CHECK IF YOU HAVE ANY PROBLEMS IN THE FOLLOWING AREAS:**

_____ Abdomen	_____ Eyes	_____ Heart	_____ Neck
_____ Arms, Shoulder, Hands	_____ Fatigue	_____ Lungs	_____ Nose
_____ Back	_____ Feet, Hips, Legs	_____ Mental	_____ Nutrition/Weight
_____ Bowels/Urine	_____ Genitals	_____ Mouth/Teeth/Throat	_____ Sensation
_____ Ears	_____ Head	_____ Muscle Strength	_____ Skin

Explanations \_\_\_\_\_  
 \_\_\_\_\_

PHYSICAL EXAMINATION

B.P. \_\_\_\_\_ Pulse \_\_\_\_\_ Ht. \_\_\_\_\_ Wt. \_\_\_\_\_  
 Eye Chart R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ B 20/ \_\_\_\_\_  
 Hct \_\_\_\_\_ UA \_\_\_\_\_/\_\_\_\_\_

Comment if possible findings:

Abd \_\_\_\_\_ Genitalia \_\_\_\_\_ Lungs \_\_\_\_\_ Skin \_\_\_\_\_  
 Ext \_\_\_\_\_ Heart \_\_\_\_\_ Neck \_\_\_\_\_  
 General: \_\_\_\_\_ HEENT \_\_\_\_\_ Neuro \_\_\_\_\_

Explanations \_\_\_\_\_  
 \_\_\_\_\_