



**Part 1. Student Information (to be completed by students and/or parent)**

Student's Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_  
School: \_\_\_\_\_ Grade in School: \_\_\_\_\_ Sport(s): \_\_\_\_\_  
Home Address: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Name of Parent/Guardian: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_  
Person to Contact in Case of Emergency: \_\_\_\_\_  
Relationship to Student: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_  
Personal/Family Physician: \_\_\_\_\_ City/State: \_\_\_\_\_ Office Phone: (\_\_\_\_) \_\_\_\_\_

**Part 2. Medical History (to be completed by student and/or parent). Explain "yes" answers below. Circle questions you don't know the answer to.**

	Yes	No		Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?	___	___	26. Have you ever become ill from exercising in the heat?	___	___
2. Do you have an ongoing chronic illness?	___	___	27. Do you cough, wheeze or have trouble breathing during or after activity?	___	___
3. Have you ever been hospitalized overnight?	___	___	28. Do you have asthma?	___	___
4. Have you ever had surgery?	___	___	29. Do you have seasonal allergies that require medical treatment?	___	___
5. Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler?	___	___	30. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, hearing aid, retainer)?	___	___
6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	___	___	31. Have you had any problems with your eyes or vision?	___	___
7. Do you have any allergies?	___	___	32. Do you wear glasses, contacts, or protective eyewear?	___	___
8. Have you ever had a rash or hives develop during or after exercise?	___	___	33. Have you ever had a sprain, strain or swelling after injury?	___	___
9. Have you ever passed out during or after exercise?	___	___	34. Have you broken or fractured any bones or dislocated any joints?	___	___
10. Have you ever been dizzy during or after exercise?	___	___	35. Have you had any problems with pain or swelling in muscles, tendons, bones or joints?	___	___
11. Have you ever had chest pain during or after exercise?	___	___	<i>If yes, check appropriate blank and explain below:</i>		
12. Do you get tired more quickly than your friends do during exercise?	___	___	___	___	___
13. Have you ever had racing of your heart or skipped heart beats?	___	___	___	___	___
14. Have you had high blood pressure or high cholesterol?	___	___	___	___	___
15. Have you ever been told you have a heart murmur?	___	___	___	___	___
16. Has any family member or relative died of heart problems or sudden death before age 50?	___	___	___	___	___
17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	___	___	___	___	___
18. Has a physician ever denied or restricted your participation in sports for any heart problems?	___	___	___	___	___
19. Do you have any current skin problems?	___	___	___	___	___
20. Have you ever had a head injury or concussion?	___	___	___	___	___
21. Have you ever been knocked out, become unconscious or lost your memory?	___	___	___	___	___
22. Have you ever had a seizure?	___	___	___	___	___
23. Do you have frequent or severe headaches?	___	___	___	___	___
24. Have you ever had numbness or tingling in your arms, hands, legs, or feet?	___	___	___	___	___
25. Have you ever had a stinger, burner, or pinched nerve?	___	___	___	___	___
Explain "yes" answers here: _____	___	___	36. Do you want to weight more or less than you do now?	___	___
_____	___	___	37. Do you lose weight regularly to meet weigh requirements for your sport?	___	___
_____	___	___	38. Do you feel stressed out?	___	___
_____	___	___	39. Record the dates of your most recent immunizations (shots) for: Tetanus: _____ Measles: _____ Hepatitis B: _____ Chickenpox: _____	___	___
_____	___	___	<b>Females Only (optional)</b>	___	___
_____	___	___	40. When was your fist menstrual period? _____	___	___
_____	___	___	41. When was your most recent Menstrual period? _____	___	___
_____	___	___	42. How much time do you usually have from the start of one period to the start of another? _____	___	___
_____	___	___	43. How many periods have you had in the last year? _____	___	___
_____	___	___	44. What was the longest time between periods in th last year? _____	___	___

We hereby state, to the best of our knowledge, that our answers to the above questions are complete and correct.

Signature of Student: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_ Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_



**Part 3. Physical Examination (to be completed by licensed physician, licensed osteopathic physician, licensed chiropractic physician, licensed physician assistant or certified advanced registered nurse practitioner).**

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ % Body Fat (optional): \_\_\_\_\_ Pulse: \_\_\_\_\_ Blood Pressure: \_\_\_/\_\_\_(\_\_\_/\_\_\_, \_\_\_/\_\_\_)  
Visual Acuity: Right 20/\_\_\_ Left 20/\_\_\_ Corrected: Yes No Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

FINDINGS	NORMAL	ABNORMAL FINDINGS	INITIALS*
<b>MEDICAL</b>			
1. Appearance	_____	_____	_____
2. Eyes/Ears/Nose/Throat	_____	_____	_____
3. Lymph Nodes	_____	_____	_____
4. Heart	_____	_____	_____
5. Pulses	_____	_____	_____
6. Lungs	_____	_____	_____
7. Abdomen	_____	_____	_____
8. Genitalia (males only)	_____	_____	_____
9. Skin	_____	_____	_____
<b>MUSCULOSKELETAL</b>			
10. Neck	_____	_____	_____
11. Back	_____	_____	_____
12. Shoulder/Arm	_____	_____	_____
13. Elbow/Forearm	_____	_____	_____
14. Wrist/Hand	_____	_____	_____
15. Hip/Thigh	_____	_____	_____
16. Knee	_____	_____	_____
17. Leg/Ankle	_____	_____	_____
18. Foot	_____	_____	_____

\*-station-based examination only

**ASSESSMENT OF EXAMINING PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER**

I hereby certify that each examination listed above was performed by myself or an individual under my direct supervision with the following conclusion(s):

\_\_\_ Cleared without limitation  
\_\_\_ Not Cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_

\_\_\_ Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_  
\_\_\_ Referred to \_\_\_\_\_ For: \_\_\_\_\_

Recommendations: \_\_\_\_\_

Name of Physician/Physician Assistant/Nurse Practitioner (print): \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_  
Address: \_\_\_\_\_

Signature of Physician/Physician Assistant/Nurse Practitioner: \_\_\_\_\_

**ASSESSMENT OF PHYSICIAN TO WHOM REFERRED (if applicable)**

I hereby certify that the examination(s) for which referred was/were performed by myself or an individual under my direct supervision with the following conclusion(s):

\_\_\_ Cleared without limitation  
\_\_\_ Not Cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_

\_\_\_ Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_  
\_\_\_ Referred to \_\_\_\_\_ For: \_\_\_\_\_

Recommendations: \_\_\_\_\_

Name of Physician (print): \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_  
Address: \_\_\_\_\_

Signature of Physician \_\_\_\_\_