PRE-PARTICIPATION ATHLETIC PHYSICAL FORM

STUDENT HEALTH HISTORY
(Must be completed)

A. GENERAL HISTORY. Check an answer for each item

YES	NO		YES	NO	
☐	☐	1. Diabetes	☐	☐	11. High or low blood pressure
☐	☐	2. Seizures	☐	☐	12. Hernia
☐	☐	3. Dizziness	☐	☐	13. Absence of a kidney
☐	☐	4. Bleeding disorders	☐	☐	14. Absence of or, undescended testicle
☐	☐	5. Asthma, allergies	☐	☐	15. Absence of any organ
☐	☐	6. Heart Disease	☐	☐	16. Menstrual Disorder
☐	☐	7. Hearing problems	☐	☐	17. Under physician's care at present
☐	☐	8. Taking medication (type, reason, dosage)	☐	☐	18. Loss of consciousness
☐	☐	9. Any allergic reactions	☐	☐	19. Change in health during the past year
☐	☐	10. Have you ever been hospitalized?	☐	☐	20. Give date of last tetanus shot ________

Details of any answers

B. ORTHOPEDIC HISTORY: If the student has had, or now has , any of the following areas injured please give details:

1. Shoulder, arm, elbow, wrist, fingers, or thumb injury: type/when? ____

2. Hip, knee, leg, calf, ankle, foot, or toe injury: type/when? ____

3. Head, neck, or spine injury: type/when? ____

Family Doctor: ____

I/we verify that the above information is correct and I give permission for my child to receive a physical examination.

Date: _____________ Parent/Guardian signature: _____________________________________ Phone#: _________________

STUDENT ATHLETE PHYSICAL EXAMINATION

Student: ______________________________

A. PRE-PHYSICAL

Height: ______Weight: ______ Blood pressure: ________ Vision: Right ________Left _________

Dental: Braces broken or missing teeth Plates Glasses: YES NO Anisocoria: YES NO (unequal pupils)

B. GENERAL PHYSICAL

Heart____________________ Lungs ___________________ Abdomen __________________

Hernia __________________ _________ Varicocele _________________________________

C. ORTHOPEDIC EVALUATION

C Spine _________________ T Spine ___________________ L Spine ___________________

Hips/pelvis ______________ Knees ____________________ Feet/ankles/toes ____________

Shoulders _______________ Elbows ___________________ Wrists/hands/fingers _________

*☐ **Approved for athletic competition**

☐ Disapproved for athletic competition, state reason____

☐ Approved for athletic competition, refer to specialist for _______________________________________

☐ Disapproved for athletic competition, refer to specialist for ___________________________________

DATE OF PHYSICAL	PRINT NAME OF PHYSICIAN	SIGNATURE OF PHYSICIAN
MEDICAL LICENSE #	PHONE # OF PHYSICIAN	ADDRESS OF PHYSICIAN