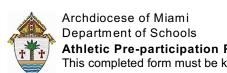


Signature of Parent/Guardian_

MUST BE COMPLETED BY PARENTS

tudent Name:			Sex:	Age	Date of Birth/	/	/		
ool: Grade in School			ort(s) expected to	play					
ome Address:									
ame of Parent/Guardian:									
erson to Contact in Case of Emergency:									
elationship to Student:									
				Office Phone: ()					
art 2. Medical History (to be completed by parent	t). Explain "yes" a	inswers be	elow. Circle ques	stions for which	you do not know the ar	ıswer			
Has child had a medical illness or injury since the last check u		l o 26	. Has child ever beco	ome ill from exercisir	g in the heat?	Yes	N		
sports physical?		27		vheeze or have trout	ole breathing during or after				
Does child have an ongoing chronic illness?			activity?						
Has child ever been hospitalized overnight?			28. Does child have asthma?						
Has child ever had surgery?			29. Does child have seasonal allergies that require medical treatment?						
Is child currently taking any prescription or nonprescription (ov counter) medications or pill or using an inhaler?	er the	30	devices that aren't	usually used for your	or corrective equipment or sport or position (for example,				
Has child ever taken any supplements or vitamins to help gain	or lose		knee brace, special hearing aid)?	e brace, special neck roll, foot orthotics, retainer on your teeth, ring aid)?					
weight or improve performance?	. food or	31	. Has child had any p	problems with his/her	eyes or vision?				
Does child have any allergies (for example to pollen, medicine stinging insects)?	e, 100d of	32	32. Does child wear glasses, contacts, or protective eye wear?						
Has child ever had rash or hives develop during or after exerci	ise?	33	33. Has child ever had a sprain, strain, or swelling after injury?						
Has child ever passed out during or after exercise?		34	34. Has child broken or fractured any bones or dislocated any joints?						
Has child ever been dizzy during or after exercise?		35	35. Has child had any other problems with pain or swelling in muscles, tendons, bones, or joints?						
Has child ever had chest pain during or after exercise?				oriate blank and exp	ain below:				
Does child get tired more quickly than friends during exercise?			Head	Elbow	Hip				
Has child ever had racing of the heart of skipped heartbeats?			Neck	Forearm	Thigh				
Has child had high blood pressure or high cholesterol?			Back	Wrist	Knee				
Has child ever been told he/she has a heart murmur?			Chest	Hand	Shin/Calf				
Has any family member or relative died of heart problems or s death before age 50?	udden		Shoulder	Finger	Ankle				
Has child had severe viral infection (for example, myocarditis	or		Upper Arm	Foot					
mononucleosis) within the last month?		36		weigh more or less t	han child weighs now?				
Has a physician ever denied or restricted child's participation if for any heart problems?	n sports		37. Does child lose weight regularly to meet weight requirements for a						
Does child have any current skin problems (for example, itchin	ng,		sport?						
rashes, acne, warts, fungus, or blisters)? Has child ever had a head injury or concussion?			Becord the dates of		nunizations (shots) for:				
Has child ever had a head figury of concussion? Has child ever been knocked out, become unconscious, or los	t his/her	ა			98:				
memory?			Hepatitus B		enpox:				
Has child ever had a seizure?					F				
Does child have frequent or severe headaches?									
Has child ever had numbness or tingling in his/her arms, hand or feet?	s, legs,								
Has child ever had a stinger, burner, or pinched nerve?									

Date:_



Signature of Physician:___

___, MD, DO, DC, ARNP

Athletic Pre-participation Physical Evaluation (Page 2 of 2) (MUST COMPLETED & DATED This completed form must be kept on file by the school BY PHYSICIAN)

Part 3. Physical Examination (to be comp	oleted by physician).						
Student Name:					Date of Birth	//	
Height: Weight:	_ % Body Fat (optiona	al):	Pulse:	Blood Pressur	re:/(/	/, ,/)
Visual Acuity: Right 20/ Left 20/	_ Corrected: Yes	No	Pupils: Equal_		Unequal	_	
FINDINGS NORMA	L	ABNORM	AL FINDINGS			INITIALS*	
MEDICAL							
1. Appearance							
2. Eyes/Ears/Nose/Throat							
3. Lymph Nodes							
4. Heart							
5. Pulses							
6. Lungs							
7. Abdomen							
8. Skin							
MUSCULOSKELETAL							
9. Neck							
10. Back							
11. Shoulder/Arm							
12. Elbow/Forearm							
13. Wrist/Hand							
14. Hip/Thigh							
15. Knee							
 16. Leg/Ankle							
17. Foot							
 * - Station-based examination only							
ASSESSMENT OF EXAMINING PHYSICIA	N.						
Cleared without limitation							
Not cleared for					Reason		
Cleared after completing evaluation/r							
Referred to							
					101		
Recommendations:							
Name of Physician (print or type):						Date:	·
						Date	
Signature of Physician:							, MD, DO, DC, ARNP
ASSESSMENT OF PHYSICIAN TO WHOM	A REFERRED (if anni	icable)					,, 50, 50, 70, 70, 70
hereby certify that the examination(s) for w			hy myself or an indi	ividual under my	direct supervision with the	he following conc	lusion(s)
Cleared without limitation	inch referred was/we	e periorited	by mysen or an mu	ividual dilder iliy	unect supervision with th	ne ronowing conc.	usion(s)
					Bassan		
Cleared after completing evaluation/r							
Referred to							
Recommendations:							
Name of Physician (print or type):						Date:	
Address:							

Based on recommendations developed by the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine and American Osteopathic Academy for Sports Medicine.