

PART III – PHYSICAL EXAMINATION
(To be completed and signed by examining physician)

NAME _____ SPORT _____

HEIGHT _____ WEIGHT _____ SEX _____ AGE _____ YEAR _____

*Tanner Stage or Maturation Index _____

BP _____

*Percent Body Fat _____

*Pulse (rest) _____

(Exercise) _____

(Recovery) _____

*Vision: Corrected (L) _____ (R) _____ Both _____

Uncorrected (L) _____ (R) _____ Both _____

*Audiogram: _____

Cervical spine/neck _____

Back _____

Eyes _____

Shoulders _____

Ears _____

Arm/elbow/wrist/hand _____

Nose _____

Knees/hips _____

Throat _____

Ankles/feet _____

Teeth _____

Skin _____

Lab: _____

Lymphatic _____

*Urine _____

Lungs _____

*Hemoglobin or HCT _____

Heart _____

and/or Fe Stores _____

Abdomen _____

Genitalia/hernia _____

Peripheral pulses _____

***WHEN MEDICALLY INDICATED**

I have reviewed the data above, reviewed his/her medical history form and make the following recommendations for his/her participation in athletics.

_____ Full Participation _____ Limited Participation
_____ No Participation _____ Needs Additional Evaluation

If not full participation give reasons & recommendations: _____

Any recommendations or concerns on such items as:

- a. Weight loss or gain or restrictions of weight loss: _____
- b. Slow and careful monitoring of conditioning because of being overweight or show an abnormal exercise testing: _____

c. Other _____

Physician Signature _____, M.D.* Date _____

*Doctor of Medicine, Doctor of Osteopathy or Licensed Nurse Practitioner

Physician Name (print) _____

Address _____

City/Zip Code _____

Telephone Number _____

PART II – MEDICAL HISTORY

This form must be completed by parent or guardian prior to time of the physical examination and should be taken with physical examination form for review by the physician during the examination.

YES	NO			
___	___	1.	Have you ever had any of the following?	Please explain any YES answers
___	___		heart murmur _____	
___	___		high blood pressure _____	
___	___		other heart problems _____	
___	___		broken bones _____	
___	___		weak joints - ankles, knees _____	
___	___		concussion _____	
___	___		operation _____	
___	___		seizures or epilepsy _____	
___	___	2.	Have you ever fainted or passed out? _____	
___	___	3.	Have you ever been knocked out? _____	
___	___	4.	Have you ever been hospitalized? _____	
___	___	5.	Have you ever had to stop running after ¼ to ½ miles for chest pain or shortness of breath? _____	
___	___	6.	A. Have you ever had significant allergies to:	
___	___		bee stings? On medication- yes ___ no ___	
___	___		foods _____	
___	___		medicine _____	
___	___		others _____	
___	___		B. Do you have prescription for use of:	
___	___		Adrenaline _____	
___	___		Inhalers _____	
___	___		Other allergy medicine _____	
___	___		C: Do you have asthma? _____	
___	___	7.	Do you take any medicine regularly? _____	
___	___	8.	Have you any illnesses lasting a week or more such as mononucleosis, etc? _____	
___	___	9.	Have you had any blood disorders, including sickle cell trait, anemia, etc.? _____	
___	___	10.	Has any family member had a heart attack, heart problems or sudden death before the age of 50? _____	
___	___	11.	Do you wear contact lenses, eyeglasses or dental appliance? _____	
___	___	12.	Do you have any missing or non-functioning organs such as testes, eye, kidney, etc.? _____	
___	___	13.	Menstrual History:	
___	___		Have you begun menses yet? _____	
___	___	14.	Do you have any other significant health problems? _____	
___	___	15.	Hepatitis B Immunization Series? _____	
___	___	16.	DATE OF LAST TETANUS IMMUNIZATION? _____	