SHERIFF'S COMMUNITY IMPACT PROGRAM
2350 NORTHROP AVENUE | SACRAMENTO, CA 95825 | 916.333.6464 EXT. 2807

SPORTS PHYSICAL EXAMINATION FORM

PART 1 (To be completed by a parent or legal guardian)

Last Name	First Name	Grade

Birthdate/Age	Sport/Activity ○Boxing ○ SHOCK ○Other:	SCIP Member #

PART 2 - HEALTH HISTORY (Must be completed by Parent/Legal Guardian Prior to the Examination)

	Yes	No	Has the student had:
1	○	○	Chronic or recurrent illness?
2	○	○	Illness lasting over one week?
3	○	○	Hospitalizations or Surgeries?
4	○	○	Nervous, psychiatric, or neurologic condition?
5	○	○	Loss or nonfunctioning of organs (eye, kidney, liver, testicle) or glands?
6	○	○	Allergies (medications, insect bites, food)?
7	○	○	Problems with heart or blood pressure?
8	○	○	Chest pain or significant or severe shortness of breath during or after exercise?
9	○	○	Dizziness or fainting with exercise?
10	○	○	Fainting, bad headaches, or convulsions?
11	○	○	Potential concussion or loss of consciousness?
12	○	○	Heat exhaustion, heatstroke, or other problems managing or responding to heat?
13	○	○	Racing heartbeat, skipped or irregular heartbeats, or heart murmur?
14	○	○	Seizures or seizure disorders?
15	○	○	Severe or repeated instances of muscle cramps?
16	○	○	Injuries requiring medical care or treatment?
17	○	○	Neck or back pain or injury?
18	○	○	Knee pain or injury?
19	○	○	Shoulder or elbow pain or injury?
20	○	○	Ankle pain or injury?
21	○	○	Other joint pain or injury?
22	○	○	Broken bones (fractures)?

	Yes	No	Does this student presently:
23	○	○	Wear eyeglasses or contact lenses?
24	○	○	Wear dental bridges, braces, or plates?
25	○	○	Take any medications? (List them below)

	Yes	No	Further History:
26	○	○	Birth defects (Corrected or not)?
27	○	○	Death of a parent or grandparent less than 40 years of age due to medical cause/condition?
28	○	○	Parent or grandparent requiring treatment for heart condition less than 50 years of age?
29	○	○	Been seen by a physician on an emergency or urgent basis in the last 12-months?

Date of last known tetanus shot:_____ | Date of last complete physical examination:_____

Please explain all "YES" answers. Describe any other fact that should be disclosed prior to the examination (use reverse of form if needed):

PARENT/GUARDIAN'S AUTHORIZATION: (Please read, complete, and sign) I authorize the health care provider to perform a Sports Physical Evaluation on the student. The information set forth above is complete and accurate. I presently know of no reason why the student cannot fully and safely participate in the checked activity(ies) above.

Print Name of Parent or Legal Guardian	Signature of Parent or Legal Guardian

PART 3 – MEDICAL EVALUATION (To be completed by the examining Health Care Provider)

This evaluation can only be performed by Medical Doctor (MD), Doctor of Osteopathy (DO), Physician's Assistant (PA), Nurse Practitioners (NP)

	NORMAL	ABNORMAL (Describe)
Eyes/Ears/Nose/Throat		
Heart, lungs, pulmonary function		
Abdomen, genital/hernia (males)		
Skin and musculoskeletal:		
A. neck/spine/shoulders/back		
B. arms/hands/fingers		
C. hips/thighs/knees/legs		
D. feet/ankles		
Neurologic Screening Exam (NSE)		
Concussion Screening Evaluation		

Height: Weight:

Pulse: After Ex:

BP:

Recommendation

○ Unlimited participation
○ Limited participation
○ Clearance withheld pending further evaluation/testing
○ No athletic participation

One of the above MUST be checked by the physician

Comments:

Print Name of Physician	Physician's Signature	Date