



## SPORTS PHYSICAL EXAMINATION FORM

PART 1 (To be completed by a parent or legal guardian)			
Last Name	First Name		Grade
Birthdate/Age	Sport/Activity <input type="radio"/> Boxing <input type="radio"/> SHOCK <input type="radio"/> Other:	SCIP Member #	

PART 2 - HEALTH HISTORY (Must be completed by Parent/Legal Guardian Prior to the Examination)			
	<b>Yes</b>	<b>No</b>	<b>Has the student had:</b>
1	<input type="radio"/>	<input type="radio"/>	Chronic or recurrent illness? 16 <input type="radio"/> <input type="radio"/>
2	<input type="radio"/>	<input type="radio"/>	Illness lasting over one week? 17 <input type="radio"/> <input type="radio"/>
3	<input type="radio"/>	<input type="radio"/>	Hospitalizations or Surgeries? 18 <input type="radio"/> <input type="radio"/>
4	<input type="radio"/>	<input type="radio"/>	Nervous, psychiatric, or neurologic condition? 19 <input type="radio"/> <input type="radio"/>
5	<input type="radio"/>	<input type="radio"/>	Loss or nonfunctioning of organs (eye, kidney, liver, testicle) or glands? 20 <input type="radio"/> <input type="radio"/>
6	<input type="radio"/>	<input type="radio"/>	Allergies (medications, insect bites, food)? 21 <input type="radio"/> <input type="radio"/>
7	<input type="radio"/>	<input type="radio"/>	Problems with heart or blood pressure? 22 <input type="radio"/> <input type="radio"/>
8	<input type="radio"/>	<input type="radio"/>	Chest pain or significant or severe shortness of breath during or after exercise? 23 <input type="radio"/> <input type="radio"/>
9	<input type="radio"/>	<input type="radio"/>	Dizziness or fainting with exercise? 24 <input type="radio"/> <input type="radio"/>
10	<input type="radio"/>	<input type="radio"/>	Fainting, bad headaches, or convulsions? 25 <input type="radio"/> <input type="radio"/>
11	<input type="radio"/>	<input type="radio"/>	Potential concussion or loss of consciousness? 26 <input type="radio"/> <input type="radio"/>
12	<input type="radio"/>	<input type="radio"/>	Heat exhaustion, heatstroke, or other problems managing or responding to heat? 27 <input type="radio"/> <input type="radio"/>
13	<input type="radio"/>	<input type="radio"/>	Racing heartbeat, skipped or irregular heartbeats, or heart murmur? 28 <input type="radio"/> <input type="radio"/>
14	<input type="radio"/>	<input type="radio"/>	Seizures or seizure disorders? 29 <input type="radio"/> <input type="radio"/>
15	<input type="radio"/>	<input type="radio"/>	Severe or repeated instances of muscle cramps? 30 <input type="radio"/> <input type="radio"/>
			<b>Injuries requiring medical care or treatment?</b>
			<b>Neck or back pain or injury?</b>
			<b>Knee pain or injury?</b>
			<b>Shoulder or elbow pain or injury?</b>
			<b>Ankle pain or injury?</b>
			<b>Other joint pain or injury?</b>
			<b>Broken bones (fractures)?</b>
			<b>Does this student presently:</b>
	<input type="radio"/>	<input type="radio"/>	Wear eyeglasses or contact lenses?
	<input type="radio"/>	<input type="radio"/>	Wear dental bridges, braces, or plates?
	<input type="radio"/>	<input type="radio"/>	Take any medications? (List them below)
			<b>Further History:</b>
	<input type="radio"/>	<input type="radio"/>	Birth defects (Corrected or not)?
	<input type="radio"/>	<input type="radio"/>	Death of a parent or grandparent less than 40 years of age due to medical cause/condition?
	<input type="radio"/>	<input type="radio"/>	Parent or grandparent requiring treatment for heart condition less than 50 years of age?
	<input type="radio"/>	<input type="radio"/>	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
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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			Height: _____ Weight: _____
Heart, lungs, pulmonary function			Pulse: _____ After Ex: _____
Abdomen, genital/hernia (males)			BP: _____
Skin and musculoskeletal:			<b>Recommendation</b> <input type="radio"/> Unlimited participation <input type="radio"/> Limited participation <input type="radio"/> Clearance withheld pending further evaluation/testing <input type="radio"/> No athletic participation <b>One of the above MUST be checked by the physician</b>
A. neck/spine/shoulders/back			
B. arms/hands/fingers			
C. hips/thighs/knees/legs			
D. feet/ankles			
Neurologic Screening Exam (NSE)			
Concussion Screening Evaluation			
<b>Comments:</b>			
Print Name of Physician	Physician's Signature		Date