Rescue Union School District - SPORTS PHYSICAL EXAMINATION FORM

PART 1 (TO BE COMPLETED BY STUDENT AND PARENT(S OR GUARDIAN)

LAST NAME	FIRST NAME	GRADE

BIRTHDATE	FALL SPORT	WINTER SPORT	SPRING SPORT	STUDENT ID NUMBER

HEALTH HISTORY (Must be completed prior to the examination)

	Yes	No	Has this student had any:
1.	☐	☐	Chronic or recurrent illness?
2.	☐	☐	Illness lasting over 1 week?
3.	☐	☐	Hospitalizations or Surgery?
4.	☐	☐	Nervous, psychiatric, or neurologic condition?
5.	☐	☐	Loss or nonfunctioning of organs (eye, kidney, liver, testicle) or glands?
6.	☐	☐	Allergies (medicines, insect bites, food)?
7.	☐	☐	Problems with heart or blood pressure?
8.	☐	☐	Chest pain or severe shortness of breath with exercise?
9.	☐	☐	Dizziness or fainting with exercise?
10.	☐	☐	Fainting, bad headaches or convulsions?
11.	☐	☐	Concussion or loss of consciousness?
12.	☐	☐	Heat exhaustion, heatstroke, or other problems with heat?
13.	☐	☐	Racing heart, skipped, irregular heartbeats, or heart murmur?
14.	☐	☐	Seizures?
15.	☐	☐	Severe or repeated instances of muscle cramps?

	Yes	No	Does this student:
16.	☐	☐	Wear eyeglasses or contact lenses?
17.	☐	☐	Wear dental bridges, braces or plates?
18.	☐	☐	Take any medications? (List below):

	Yes	No	Is there any history of:
19.	☐	☐	Injuries requiring medical care or treatment?
20.	☐	☐	Neck or back pain or injury?
21.	☐	☐	Knee pain or injury?
22.	☐	☐	Shoulder or elbow pain or injury?
23.	☐	☐	Ankle pain or injury?
24.	☐	☐	Other joint pain or injury?
25.	☐	☐	Broken bones (fractures)?

	Yes	No	Further history:
26.	☐	☐	Birth defects (corrected or not)?
27.	☐	☐	Death of parent or grandparent less than 40 years of age due to medical cause or 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 (lockjaw) shot: _____

Date of last complete physical examination: _____

Explain all "YES" answers here along with any other fact or circumstance that should be disclosed to the examining physician (use reverse of form if needed):

PARENT/GUARDIAN'S AUTHORIZATION: I authorize a physician to perform a Sports Physical Evaluation on the student. The information set forth above is complete and accurate and I know of no reason why the student cannot fully and safely participate in the listed sports. I understand that this is solely a screening examination and that the absence of any health conditions or concerns listed below does not mean that student is free from actual or potential harmful health conditions that may cause the student injury or death while participating in sports. Any question or concern I may have regarding the student's health or safety will be referred to our personal physician for review and evaluation.

PRINT NAME OF PARENT OR GUARDIAN	SIGNATURE OF PARENT OR GUARDIAN		
ADDRESS	WORK PHONE	HOME PHONE	DATE
REGULAR PHYSICIAN'S NAME	OFFICE PHONE		

PART 11 (TO BE COMPLETED BY THE EXAMINING PHYSICIAN)

	NORMAL	ABNORMAL (Describe)	
Eyes/Ears/Nose/Throat			Height:
Skin			Weight:
Heart			Pulse: After Ex:
Abdomen			BP:
Genital/hernia (males)			***Recommendation:***
Musculoskeletal:			☐ Unlimited participation
a. Neck/Spine/Shoulders/Back			☐ Limited participation/specific sports, events or activities
b. Arms/Hands/Fingers			☐ Clearance withheld pending further testing/evaluation
c. Hips/Thighs/Knees/Legs			☐ No athletic participation
d. Feet/Ankles			***One of the above MUST be checked.***
Neurologic Screening Exam (NSE)			

Comments:

PRINT NAME OF PHYSICIAN (M.D. Only)	PHYSICIAN'S SIGNATURE	DATE