Our Savior Christian Academy – Sports Physical Form

Name: _____ Gender: M F

Date of Birth: ___/___/___ Current Grade Placement: _____

Emergency Contact Person: _____

Contact Phone: _____

Please indicate MEDICAL ALERTS such as allergic reactions, contact lenses, etc.:

_____

PHYSICAL EXAM – TO BE COMPLETED BY PHYSICIAN

Height _____ Weight _____ Pulse _____Blood Pressure _____

	Normal	Abnormal Findings
1. Eyes		
2. Ears, Nose, Throat		
3. Mouth & Teeth		
4. Neck		
5. Cardiovascular		
6. Chest & Lungs		
7. Abdomen		
8. Skin		
9. Genitalia-Hernia (male)		
10. Musculoskeletal: ROM, strength, etc.		
a. neck		
b. spine		
c. shoulders		
d. arms / hands		
e. hips		
f. thighs		
g. knees		
h. ankles		
i. feet		
11. Neuromuscular		

Medical History:
To be completed by parent or guardian. Please answer *yes or no* to the following.

1. Has anyone in the athlete's family (grandparents, mother, father, brother, sister, aunt, uncle) died suddenly before age 50?

2. Has the athlete ever stopped exercising because of dizziness or passed out during exercise?

3. Does the athlete have asthma (wheezing), hay fever, or coughing spells after exercise?

4. Has the athlete ever had a broken bone, had to wear a cast, or had an injury to any joint?

5. Does the athlete have a history of concussion (getting knocked out)?

6. Has the athlete ever suffered a heat-related illness (heat stroke)?

7. Does the athlete have a chronic illness or see a doctor regularly for any particular problem?

8. Does the athlete take any medication(s)?

9. Is the athlete allergic to any medications or bee stings?

10. Does the athlete have only one of any paired organs? (Eyes, ears, kidneys, testicles, ovaries)

11. Has the athlete had an injury in the last year that caused the athlete to miss 3 or more consecutive days of practice or competition?

12. Has the athlete had surgery or been hospitalized in the past year?

13. Has the athlete missed more than 5 consecutive days of participation in usual activities because of illness, or has the athlete had a medical illness diagnosed that has not been resolved in the past year?

14. Is there any concern about any problem or condition at this time?

Physician Alert:
Parents please give details to anything answered "YES" to the above health history.
Please Print/ Stamp Physician Information:

Certifying Information:

Without Restrictions:
I certify that I have examined this athlete and found him/her medically qualified to participate in sports. I also certify that I am a licensed medical physician, physician's assistant, or family nurse practitioner.

Physician Signature _____Date_____

With Restrictions:
I certify that I have examined this athlete and found him/her medically qualified to participate in sports with the following restrictions. I also certify that I am a licensed medical physician, physician's assistant, or family nurse practitioner.

Identified Restrictions:

Physician Signature _____Date: _____