

Student Athlete Physical Exam Form

St. Dominic School Athletic Program

Student Athlete's Name _____

LAST

FIRST

MIDDLE

School Year: _____ Grade: _____ Birthdate: ____/____/____

Parent/Guardian Name(s) _____

Address where child resides: _____

I am planning to participate in the following (circle all programs you might try to play):

Baseball

Basketball

Football

Volleyball

Cheerleading

PART I - MEDICAL HISTORY

To be completed by the parent and student and presented to the health care provider before the physical.

CIRCLE THE APPROPRIATE RESPONSE TO EACH ITEM:

- | | | |
|---|-----|----|
| 1. Have you ever been hospitalized? | YES | NO |
| 2. Have you ever had surgery of any kind (e.g., tonsillectomy) | YES | NO |
| 3. Are you presently taking any medications or pills? | YES | NO |
| 4. Do you have any allergies (medicine, bees, or other insects)? | YES | NO |
| 5. Have you ever passed out during exercise? | YES | NO |
| 6. Have you ever been dizzy during or after exercise? | YES | NO |
| 7. Have you ever had chest pain during or after exercise? | YES | NO |
| 8. Have you ever had high blood pressure? | YES | NO |
| 9. Have you ever been told you have a heart murmur? | YES | NO |
| 10. Have you ever had racing of your heart? | YES | NO |
| 11. Has anyone in your family died of heart problems before 50? | YES | NO |
| 12. Do you have any skin problems? (itching, rashes, acne) | YES | NO |
| 13. Have you ever had a head injury? | YES | NO |
| 14. Have you ever been knocked out or unconscious? | YES | NO |
| 15. Have you ever had a seizure or suffer from epilepsy? | YES | NO |
| 16. Have you ever had a stinger, burner or pinched nerve? | YES | NO |
| 17. Have you ever had heat related problems? | YES | NO |
| 18. Have you ever been dizzy or passed out in the heat? | YES | NO |
| 19. Do you cough heavily, or breath heavily during activity? | YES | NO |
| 20. Do you use any special equipment (e.g., knee brace)? | YES | NO |
| 21. Have you had any problems with your eyes or vision? | YES | NO |
| 22. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones? | YES | NO |
| 23. Are you missing one of any paired organs (e.g., eyes) | YES | NO |
| 24. Have you ever been diagnosed with any form of asthma? | YES | NO |
| 25. Are you using an inhaler for asthma? | YES | NO |
| 26. Are you diabetic? | YES | NO |
| 27. Do you administer insulin to yourself? | YES | NO |
| 28. Are you presently using tobacco in any form? | YES | NO |
| 29. Do you have a history of sickle-cell anemia in your family? | YES | NO |
| 30. Have you had any other medical problems? | YES | NO |
| 31. Have you had a medical problem or injury within the last year? | YES | NO |
| 32. When was your last tetanus shot? _____ | | |

Please explain any YES answers from questions 1-31. _____

PART II - PHYSICAL EXAMINATION *To be completed by the authorized health care provider.*

PATIENT NAME: _____

HEIGHT _____ WEIGHT _____ BP _____ / _____ PULSE _____
 VISION R- 20/ _____ L- 20/ _____ BOTH- 20/ _____ CORRECTED? Y N

	Normal	Abnormal	Comment
HEART	_____	_____	_____
Rhythm (Regular/Irregular)	_____	_____	_____
Murmur (supine)	_____	_____	_____
Murmur (standing)	_____	_____	_____
ENT	_____	_____	_____
Lungs	_____	_____	_____
Skin	_____	_____	_____
Abdominal	_____	_____	_____
Genitalia	_____	_____	_____
Musculoskeletal	_____	_____	_____
Neck	_____	_____	_____
Shoulder	_____	_____	_____
Elbow	_____	_____	_____
Wrist	_____	_____	_____
Hand	_____	_____	_____
Back	_____	_____	_____
Knee	_____	_____	_____
Ankle	_____	_____	_____
Foot	_____	_____	_____
Dental	_____	_____	_____
Other _____	_____	_____	_____

After reviewing the data above and the student's medical history, I make the following recommendations:

- _____ Cleared
- _____ Cleared after additional evaluation for _____
- _____ Restricted from participating in the sport(s) of _____
- _____ Cleared only to participate in the sport(s) of _____

Recommendations/Restrictions (attach additional if necessary)

I have examined the physical condition of the student and find the said student to be physically fit to practice for and participate in athletic contests.

Provider Name (print) _____ Phone _____

Address _____ City/State/Zip _____

AUTHORIZED SIGNATURE _____ DATE _____

This Physical Examination is valid for one year from date