THIS QUESTIONAIRE IS FOR PATIENT'S MEDICAL RECORD ONLY DO NOT RETURN TO SCHOOL PLEASE FILL OUT PRIOR TO YOUR APPOINTMENT

SPORTS PHYSICAL PHYSICIAN OFFICE FORM

Name: Date of Birth: Student ID:

Sports: School: Grade: Male D Female D

EXPLAIN YES ANSWERS BELOW CIRCLE QUESTIONS YOU DO NOT UNDERSTAND

Yes No INFECTION RISK: Yes No

1. Has a doctor ever denied or restricted your D D 1. Do you have a history of recurrent
participation in sports? or persistent rashes, pressure sores,
2. Do you have a medical condition (asthma/diabetes)? D D herpes, or other skin infections? D D
CARDIAC RISK: 2. Have you ever been diagnosed or treated for
1. Has any relative died of a heart condition suddenly a MRSA infection? D D
before age 50? D D 3. History of Mono (EBV) in the last 4 weeks? D D

2. Do you or your relatives have a history of:

4. History of recurrent unexplained fevers,

or chronic coughing? D D a. Heart muscle disease such as hypertrophic 5. Do you or any members

Signature of athlete: __________ Signature of parent/guardian: ________ Date: ____ _

SPORTS PHYSICAL SCHOOL FORM

I grant permission to release the information below to School Personnel.

Signature of Parent/Guardian:---------------

NAME: Date of Birth: Student ID:

Sports: School: Grade:
Emergency Contact: Cell Phone: Home Phone: ALLERGIES: MEDICATIONS:

Date of Exam: Height: Weight: BMI: Pulse: BP:

- -'-- HEARING: D Passed Right/Left ~25dcbls (all frequencies)

D Failed D Not Done

Vision: R 20/_ L 20/_ Both 20/_ Corrected: D Y D N
U/A: D Normal-----------
REQUIRED IMMUNIZATIONS: Measles, Mumps, Rubella, Hepatitis B, Pollo, Tetanus, Pertussis, and Varicella/illness.
D Up to date (See Attached Vaccine Documentation) D Not up to date, Vaccines Needed: -------- 0 Baseline Concussion Assessment

MEDICAL: NORMAL
General Aooearance
Head eves/ears/nose/throat
Neck
Respiratory
Heart
Pulses
Abdomen
Skin
Neuro
LvmDh Nodes
Genitourinarv (males only)
MUSCULOSKELETAL: NORMAL Back (Including scoliosis screen)
Shoulder/Ann
Elbow/Forearm
Wrist/Hand/Fingers
Hil>IThiAh
Knee

Leg/Ankle
Foot/Toes

Assessment/Plan:--------------

0 Cleared for all sports without restrictions

ABNORMAL RNDINGS

ABNORMAL RNDINGS

OFFICE STAMP:

D Not Cleared for: D All sports D Certain sports: _______ _
Reason: ___________________ _

D Deferred requires further evaluation (See Recommendations Below):
D Cleared with restrictions (See Recommendations Below):
Recommendations: _________________________________ _

Name of Physician (print): __________ Address:----------Phone: _____ _

Signature of Physician: M.D., D.O., or N.P. Date: ______ _
Based on recommendations developed by the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopedic Society for Sports Medicine and American Osteopathic Academy for Sports Medicine. Rev. March 2012