PRE-PARTICIPATION ATHLETIC PHYSICAL FORM

STUDENT HEALTH HISTORY
(Must be completed)

A. GENERAL HISTORY. Check an answer for each item

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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</table>
| ☐ ☐ | 1. Diabetes
| ☐ ☐ | 2. Seizures
| ☐ ☐ | 3. Dizziness
| ☐ ☐ | 4. Bleeding disorders
| ☐ ☐ | 5. Asthma, allergies
| ☐ ☐ | 6. Heart Disease
| ☐ ☐ | 7. Hearing problems
| ☐ ☐ | 8. Taking medication (type, reason, dosage)
| ☐ ☐ | 9. Any allergic reactions
| ☐ ☐ | 10. Have you ever been hospitalized?
| ☐ ☐ | 11. High or low blood pressure
| ☐ ☐ | 12. Hernia
| ☐ ☐ | 13. Absence of a kidney
| ☐ ☐ | 14. Absence of or, undescended testicle
| ☐ ☐ | 15. Absence of any organ
| ☐ ☐ | 16. Menstrual Disorder
| ☐ ☐ | 17. Under physician's care at present
| ☐ ☐ | 18. Loss of consciousness
| ☐ ☐ | 19. Change in health during the past year
| ☐ ☐ | 20. Give date of last tetanus shot ________

Details of any answers

B. ORTHOPEDIC HISTORY: If the student has had, or now has, any of the following areas injured please give details:

1. Shoulder, arm, elbow, wrist, fingers, or thumb injury: type/when? 

2. Hip, knee, leg, calf, ankle, foot, or toe injury: type/when? 

3. Head, neck, or spine injury: type/when? 

Family Doctor: ____________________________

I/we verify that the above information is correct and I give permission for my child to receive a physical examination.

Date: __________________ Parent/Guardian signature: __________________ Phone#: __________________

STUDENT ATHLETE PHYSICAL EXAMINATION

Student: __________________________

A. PRE-PHYSICAL

Height: _______ Weight: _______ Blood pressure: _______ Vision: Right _______ Left _______

Dental: Braces broken or missing teeth Plates Glasses: YES NO Anisocoria: YES NO (unequal pupils)

B. GENERAL PHYSICAL

Heart _______ Lungs _______ Abdomen _______

Hernia _______ Varicocele _______

C. ORTHOPEDIC EVALUATION

C Spine _______ T Spine _______ L Spine _______

Hips/pelvis _______ Knees _______ Feet/ankles/toes _______

Shoulders _______ Elbows _______ Wrist/hands/fingers _______

*☐ Approved for athletic competition

☐ Disapproved for athletic competition, state reason __________________________________________

☐ Approved for athletic competition, refer to specialist for ______________________________________

☐ Disapproved for athletic competition, refer to specialist for _____________________________________

DATE OF PHYSICAL __________________ PRINT NAME OF PHYSICIAN __________________

SIGNATURE OF PHYSICIAN __________________

MEDICAL LICENSE # __________________ PHONE # OF PHYSICIAN __________________

ADDRESS OF PHYSICIAN __________________