RLA ATHLETIC PHYSICAL EXAM

HISTORY

Date: _____

Name: _____ **Phone:** (_____) _____

Address: _____ **City:** _____ **Zip:** _____

Sex: M F **Age:** _____ **Date of Birth:** _____ **Grade:** _____

Personal Physician: _____ **Phone:** (_____) _____

Previous school attended and dates: _____

Explain "Yes" answers below:	Yes	No
1. Have you ever been hospitalized?	☐	☐
Have you ever had surgery?	☐	☐
Are you presently under a doctor's care?	☐	☐
2. Are you presently taking any medications or pills?	☐	☐
3. Do you have any allergies (medicine, bees, or other)?	☐	☐
4. Have you ever passed out during or after exercise?	☐	☐
Have you ever been dizzy during or after exercise?	☐	☐
Have you ever had high blood pressure?	☐	☐
Have you ever been told you have a heart murmur?	☐	☐
Have you ever had racing of your heart or skipped heartbeats?	☐	☐
Has anyone in your family died of heart problems or a sudden death before age 50?	☐	☐
Has anyone in your family had Marfan's syndrome?	☐	☐
5. Do you have any skin problems (itching, rashes, acne)?	☐	☐
6. Have you ever had a head injury?	☐	☐
Have you ever been knocked our or unconscious?	☐	☐
Have you ever had a seizure, "fit" or epilepsy?	☐	☐
Have you ever had a stinger, burner or pinched nerve?	☐	☐
7. Have you ever had heat cramps, heat illness or muscle cramps?	☐	☐
8. Do you have trouble breathing or do you cough during or after activity?	☐	☐
9. Do you use any special equipment (pads, braces, neck rolls, eye guards, etc.)?	☐	☐
10. Have you had any problems with your eyes or vision?	☐	☐
Do you wear glasses or contacts or protective eye wear?	☐	☐
11. Are you missing an eye, kidney, or testicle?	☐	☐
12. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints?		
☐ Head ☐ Shoulder ☐ Thigh ☐ Neck ☐ Elbow ☐ Knee ☐ Foot		
☐ Forearm ☐ Shin/Calf ☐ Back ☐ Wrist ☐ Ankle ☐ Hip ☐ Hand		
13. Have you had any other medical problems (infectious mononucleosis, diabetes, anemia, etc.)?	☐	☐
14. Have you had a medical problem or injury since your last evaluation?	☐	☐
15. When was our last tetanus shot?	☐	☐
16. When was your first menstrual period?	☐	☐
When was your last menstrual period?	☐	☐
What was the longest time between your periods last year?	☐	☐

Explain "Yes" answers:

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.

Signature of Athlete: _____ **Date:** _____

Signature of Parent/Guardian: _____ **Date:** _____

PHYSICAL EXAMINATION **Date:_____**

Name: _____ Age: _____ Date of Birth _____

Height _____ Weight _____ BP: _____/_____ Pulse: _____ Vision: R 20/_____ L 20/ _____ Corrected: Y N Pupils (Circle) Equal/Unequal R>L L>R		
	Circle (if option given)	**Specific Findings**
Marfan's syndrome stigmata	No Yes	
Heart		
Rhythm	Regular Irregular	
Murmur (supine)	No Yes	
Murmur (standing)	No Yes	
	Normal (□)	**Specific Findings**
Lungs		
Skin		
Abdominal		
Femoral Pulses		
Genitalia/Hernia		
Musculoskeletal:		
Neck		
Shoulders		
Elbows		
Wrists		
Hands		
Back		
Knees		
Ankles		
Feet		
Other		

Clearance:
A. Cleared
B. Cleared after completing evaluation/rehabilitation for: _____
C. Not cleared
Due to: _____
Recommendation: _____
_____
_____

I hereby certify that this athlete was examined by me. At that time, no physical condition was detected which would reasonably be anticipated to render this athlete physically unfit to engage in any sport, except those marked below:
Sports: Baseball, Basketball, Cross Country, Football, Soccer, Track, Wrestling, Softball, Volleyball

Name of Physician: _____ Date: _____

Address: _____ Phone: (_____) _____

Signature of Physician: _____

(Based on recommendations developed by the American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine and American Osteopathic Academy of Sports Medicine.)