



Heritage Academy Sports Physical

Student: _____

This portion is to be filled out by the patient and their parents prior to seeing the physician.

Y	N	Yes = Y	No = N	Y	N	Yes = Y	No = N	
		Have you had a medical illness or injury since your last check-up or sports physical?				Have you ever had a head injury or concussion?		
		Do you have an ongoing or chronic illness?				Have you ever been knocked out, become unconscious, or lost your memory?		
(Explain Yes Answers)						Have you ever had a seizure?		
		Have you ever been hospitalized overnight?				Do you have frequent or severe headaches?		
		Have you ever had surgery?				Have you ever had numbness or tingling in your arms, hands, legs, or feet?		
(Explain Yes Answers)						Have you ever had a stinger, burner, or pinched nerve?		
				(Explain Yes Answers)				
		Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?				Have you ever become ill from exercising in the heat?		
		Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?				Do you cough, wheeze, or have trouble breathing during or after activity?		
(List medications, herbal and nutritional supplements, vitamins)						Do you suffer from asthma?		
		Do you have any allergies (For example, to pollen, medicine, food, or stinging insects)?				Do you have seasonal allergies that require medical treatment?		
(Explain Yes Answers)				(Explain Yes Answers)				
		Have you ever had a rash or hives develop during or after exercise?				Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck rolls, foot orthotics, retainer on your teeth, hearing aids)?		
(Explain Yes Answers)				(Explain Yes Answers)				
		Have you ever passed out during or after exercise?				Have you had any problems with your eyes or vision?		
		Have you ever been dizzy during or after exercise?				Do you wear glasses, contacts, or protective eyewear?		
		Have you ever had chest pain during or after exercise?		(Explain Yes Answers)				
		Do you get tired more quickly than your friends do during exercise?				Have you ever had a sprain, strain, or swelling after injury?		
		Have you ever had racing of your heart or skipped heartbeats?				Have you broken or fractured any bones or dislocated any joints?		
		Have you had high blood pressure or high cholesterol?				Have you had any problems with pain or swelling in muscles, tendons, bones, or joints?		
		Have you ever been told you have a heart murmur?		<i>If yes, Circle the appropriate boxes and explain below:</i>				
		Has any family member or relative died of heart problems or of sudden death before age 50?				Head	Elbow	Hip
		Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?				Neck	Forearm	Thigh
		Has a physician ever denied or restricted your participation in sports for any heart problems?				Back	Wrist	Knee
(Explain Yes Answers)						Chest	Hand	Shin/Calf
		Do you have any current skin problem (for example, itching, rashes, acne, warts, fungus, or blisters)?				Shoulder	Finger	Ankle
		Do you want to weigh more or less than you do now?				Upper Arm		Foot
		Do you lose weight regularly to meet weight requirements of your sport?		FEMALES ONLY				
		Do you feel stressed out?		When was your last menstrual period? _____				
(Explain Yes Answers)				How old were you when you had your first menstrual period? _____				
Record the dates of your most recent immunizations (shots):				How much time do you usually have from the start of one period to the start of another? _____				
		Tetanus _____	Measles _____	How many periods have you had in the 12 months? _____				
		Hepatitis B _____	Chickenpox _____					

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

Signature of athlete: _____ Signature of parent/guardian: _____ Date: ____ - ____ - ____

Emergency Contact: Name: _____ Relationship: _____ Phone (H) _____ (W) _____

Physician Section

Sports athlete will participate in:

- Basketball
- Soccer
- Track
- Volleyball
- Other: _____

Height _____ Weight _____ Body fat (optional) ___% Pulse _____ BP ____/____ (____/____, ____/____)

Vision: R 20/____ L 20/____ Corrected Y / N Pupils: Equal _____ Unequal _____

MEDICAL	Normal	Abnormal
Appearance		
Eyes/Ears/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia (male only)		
Skin		

MUSCULOSKETAL	Normal	Abnormal
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wristband		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		

Describe Abnormal Findings:

CLEARANCE

Cleared

Cleared after completing evaluation/rehabilitation for: _____

Not cleared for: _____ Reason: _____

Recommendations: _____

Name of physician (print/type) _____ Date: _____

Signature of physician _____, (MD/DO/ARNP/Chiropractor)

Address _____ Phone: _____