OLIVER AMES TIGERS SPORTS PHYSICAL

This side should be filled out and signed by a parent/guardian. Please Print Legibly

Name: ______________________ Male: ______ Female: ______ Grade: ______

Sport(s): ______________________ Date of Birth: ____/____/____ Age: ______

Home Address: ______________________ Telephone: ______________

Parent/Guardian: ______________________ Telephone: ______________

Parent/Guardian: ______________________ Telephone: ______________

Health Insurance Company: ______________________ Policy Holder: ______________

Primary Care Physician: ______________________ Telephone: ______________

Dentist: ______________________ Telephone: ______________

PLEASE ANSWER THE FOLLOWING QUESTIONS HONESTLY

Yes No 1. Do you or have you ever had an ongoing or chronic illness?
Yes No 2. Have you ever been hospitalized overnight?
Yes No 3. Have you ever had surgery?
Yes No 4. Do you have a single organ? If yes, which one? (Example: 1 kidney)
Yes No 5. Are you currently taking any prescription or over the counter medications?
Yes No 6. Do you have any allergies to food, medication, stinging insects or pollen?
Yes No 6a If yes, do you carry an epipen?
Yes No 7. Have you ever been dizzy, lightheaded or fainted during or after activity?
Yes No 8. Have you ever been told you have a heart murmur?
Yes No 9. Do you or any family member have a history of heart problems?
Yes No 10. Have you ever had a severe viral infection (mononucleosis)? If so, When?
Yes No 11. Have you ever had a concussion? Or had your bell rung? If so, When?
Yes No 12. Have you ever been knocked out, become unconscious or lost your memory?
Yes No 13. Do you have frequent or sever headaches?
Yes No 14. Have you ever had a seizure? When? Are you under Doctors care for them?
Yes No 15. Do you have diabetes? If yes, are you insulin dependent?
Yes No 16. Have you ever had an injury to you back that required you to refrain from activity?
Yes No 17. Do you have scoliosis?
Yes No 18. Have you ever had numbness or tingling in your arms, hands, legs, or feet?
Yes No 19. Have you ever had a stinger, burner, or a pinched nerve?
Yes No 20. Do you cough, wheeze or have trouble breathing during or after activity?
Yes No 21. Do you use an inhaler?
Yes No 22. Have you ever become ill from activity in the heat?
Yes No 23. Do you use any special protective/corrective equipment for your sport, such as orthotics, any type of brace or neck roll, etc.?
Yes No 24. Do you wear glasses or contacts during activities?
Yes No 25. Have you ever broken or fractured a bone or dislocated a joint?
Yes No 26. Have you ever had a knee injury that produced immediate and/or severe swelling?
Yes No 27. Have you ever sprained an ankle causing discolor or that forced you to use crutches?
Yes No 28. Do you have problems with shin splints?

PLEASE WRITE THE # AND THEN EXPLAIN ALL OF THE "YES" ANSWERS BELOW

____

____

______________________________ ______/______/______

Parent/Guardian Signature **Date**

OLIVER AMES TIGERS PHYSICIAN'S EXAMINATION

THIS SIDE OF THE SPORTS PHYSICAL IS TO BE FILLED OUT BY YOUR DOCTOR

Name: ____ Date of Exam: _____/_____/_______

Grade: ____________ Sport(s): ____

Height: ___________ Weight: _____________ Blood Pressure: _________/_________

Pulse: _____________ Vision: ____

Allergies: ____

Medications: ____

	NORMAL	ABNORMAL FINDINGS
Hearing/Ears	________	________________________________
Vision/Eyes	________	Contacts/Glasses__Y__N________________
Nose/Throat	________	________________________________
Mouth/Teeth	________	________________________________
Neck	________	________________________________
Head	________	Concussion__Y__N___When?______________
		________________________________
Heart	________	Any known cardiac/heart condition__Y___N__________
		________________________________
		________________________________
Lungs	________	HX of Asthma__Y__N_____Inhaler__Y__N____________
		________________________________
Abdomen	________	________________________________
Elbow/Wrist/Hand	________	________________________________
Shoulders	________	________________________________
Spine/Back	________	________________________________
Hip/Thigh	________	________________________________
Knee	________	________________________________
Ankle/Foot	________	________________________________
Skin/Lymphatics	________	________________________________
Genitalia	________	________________________________
Neurological	________	________________________________

COMMENTS:____

____

I hereby certify that this athlete is:

_________ Cleared for full participation in athletics @ Oliver Ames High School & Easton Junior High School

_________ Cleared after completing further evaluation for the following:_________________

____

_________ Denied participation in athletics @ Oliver Ames High School & Easton Junior High School for the following reason(s):_______________________________________

______________________________ ______________________________

(Please Print) Physicians Name **Physicians Signature**