Sports Physical Evaluation

NAME OF ATHLETE:	MALE:	FEMALE:

AGE:	D.O.B.	PARENTS' NAME:

1. Have you ever been told not to participate in any sport? a. Which Sport: b. When:	
2. Have you ever been unconscious or had lost of memory?	
3. Is there any history for loss of consciousness during exercise?	
4. Do you have a seizure disorder (epilepsy)?	
5. Have you ever had a serious injury?	
6. Do you have any allergies? a. Please specify i.e. hay fever, medication, etc.	
7. Do you take any medication on a regular basis?	
8. Do you have a diabetes?	
9. Are you immunizations current?	
10. Do you have asthma?	
11. Do you have recurring headaches or dizziness?	
12. Have you ever broken or dislocated a bone?	
13. Do you wear any dental appliances?	
14. Have you ever had a surgical operation?	
15. Are you under a physicians care for any reason?	
16. Parents/Guardians: do you consider the athlete to be in good health?	
Comments: Signature:_____ Date:_____	

ASSESSMENT:

Height: Weight: Blood Pressure: Pulse: Pupils:
Vision: Hearing: Breathing: Heart Rhythm: Murmur:
Muscular skeletal ROM: Neck: Shoulder: Elbows:
Wrists: Hands: Back:
Hips: Knees: Ankles: Feet:
Pain during ROM:

Immunizations are up to date and current:

I have reviewed the history and on the basis of the examination and medical history as furnished to me, it is **permissible / not permissible** for this student to participate in sports.

_____ _____
Physician's Signature Date of Examination