PHYSICAL PREPARATION FORM

(Please Print)

Present this completed form to doctor performing physical examination.

Athlete's INFORMATION

Athlete's Name:	Birth date: / /	Age:	Sex: ❑M ❑ F

Street address:	Cell Phone: ( )	Home phone: ( )

P.O. box:	City:	State:	ZIP Code:

Please indicate MEDICAL ALERTS such as allergic reactions, contact lenses, etc.:

MEDICAL HISTORY

1.	Has anyone in the athlete's family (grandparents, mother, father, brother, sister, aunt, YES NO Don't Know uncle) died suddenly before age 50?	❑ Yes ❑ No ❑ Don't Know
2.	Has the athlete ever stopped exercising because of dizziness or passed out during exercise?	❑ Yes ❑ No ❑ Don't Know
3.	Does the athlete have asthma (wheezing), hay fever, or coughing spells after exercise? YES NO Don't Know	❑ Yes ❑ No ❑ Don't Know
4.	Does the athlete have asthma (wheezing), hay fever, or coughing spells after exercise?	❑ Yes ❑ No ❑ Don't Know
5.	Has the athlete ever had a broken bone, had to wear a cast, or had an injury to any joint?	❑ Yes ❑ No ❑ Don't Know
6.	Does the athlete have a history of concussion (getting knocked out)?	❑ Yes ❑ No ❑ Don't Know
7.	Does the athlete take any medication(s)?	❑ Yes ❑ No ❑ Don't Know
8.	Is the athlete allergic to any medications or bee stings?	❑ Yes ❑ No ❑ Don't Know
9.	Does the athlete have only one of any paired organs? (Eyes, ears, kidneys, testicles, ovaries)	❑ Yes ❑ No ❑ Don't Know
10.	Has the athlete had an injury in the last year that caused the athlete to miss 3 or more consecutive days of practice or competition?	❑ Yes ❑ No ❑ Don't Know
11.	Has the athlete had surgery or been hospitalized in the past year?	❑ Yes ❑ No ❑ Don't Know
12.	Has the athlete missed more than 5 consecutive days of participation in usual activities?	❑ Yes ❑ No ❑ Don't Know
13.	Has the athlete had surgery or been hospitalized in the past year?	❑ Yes ❑ No ❑ Don't Know
14.	Has the athlete missed more than 5 consecutive days of participation in usual activities because of illness, or has the athlete had a medical illness diagnosed that has not been resolved in the past year?	❑ Yes ❑ No ❑ Don't Know
15.	Are you, the athlete, worried about any problem or condition at this time? Please give details on any "YES" answer from the above health history.	❑ Yes ❑ No ❑ Don't Know

PHYSICAL PREPARATION

PHYSICAL EXAM TO BE COMPLETED BY PHYSICIAN (Please Print)

Athlete's Information

Height	Weight	Pulse		Blood Pressure
Vision: R /	Uncorrected R /	Corrected L /	Uncorrected L /	Corrected /

P.O. box:	City:	State:	ZIP Code:

EXAM Normal Abnormal Findings Initial

	Normal	Abnormal	Findings
Eyes			
Ears, nose, throat			
Mouth and teeth			
Neck			
Cardiovascular			
Chest and lungs			
Abdomen			
Skin			
Genitalia-Hernia (male)			
Muskuloskeletal: ROM, strength, etc.			
Neck			
Spine			
Shoulders			
Arms and hands			
Hips			
Thighs			
Knees			
Ankles			
Feet			
Neuromuscular			

Physician's Information

Name			
Address			
City:	State:	Zip:	Phone:

I certify that I have examined this athlete and found him/her medically qualified to participate in sports. I also certify that I am a licensed medical physician, physician's assistant, or family nurse practitioner. (Doctor of Chiropractic Medicine is not satisfactory.)

Physician Signature_____Date _____

Participation Restrictions or Comments:_____

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