



SA Athletics | Physical Form

Name: _____ DOB: _____ Age: _____ Male Female

This is a screening examination for participation in sports. This does not substitute for a comprehensive examination with your child's regular physician where important preventive health information can be covered.

Directions for Athletes: Please review all questions with your parent or legal guardian and answer them to the best of your knowledge.

Directions for Parents: Please assure that all questions are answered to the best of your knowledge. If you do not understand or don't know the answer to a question please ask your doctor. Not disclosing accurate information may put your child at risk during sports activity.

Directions for Physicians: Please carefully review these questions and clarify any positive or Don't Know answers with the athlete and/or parent.

Explain "Yes" answers below	Yes	No	Don't Know
1. Does the athlete have any chronic medical illnesses (diabetes, asthma (exercise asthma), kidney problems, etc.) List:			
2. Is the athlete presently taking any medications or pills?			
3. Does the athlete have any allergies (medicine, bees or other stinging insects, latex?)			
4. Does the athlete have the sickle cell trait?			
5. Has the athlete ever had a head injury, been knocked out, or had a concussion?			
6. Has the athlete ever had a heat injury (heat stroke) or sever muscle cramps with activities?			
7. Has the athlete ever passed out or nearly passed out DURING exercise, emotion, or startle?			
8. Has the athlete ever fainted or passed out AFTER exercise?			
9. Has the athlete had extreme fatigue (been really tired) with exercise (different from other children)?			
10. Has the athlete ever had trouble breathing during exercise, or a cough with exercise?			
11. Has the athlete ever been diagnosed with exercise-induced asthma?			
12. Has a doctor ever told the athlete that he/she has high blood pressure?			
13. Has a doctor ever told the athlete that he/she has a heart infection?			
14. Has a doctor ever ordered an EKG or other test for the athlete's heart, or has the athlete ever been told that he/she has a heart murmur?			
15. Has the athlete ever had discomfort, pain, or pressure in his chest during or after exercise or complained of his/her heart "racing" or "skipping beats"?			
16. Has the athlete ever had a seizure or been diagnosed with an unexplained seizure problem?			
17. Has the athlete ever had a stinger, burner, or pinched nerve?			
18. Has the athlete ever had any problems with their eyes or vision?			
19. Has the athlete ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injury of any bones or joints? <input type="checkbox"/> Head <input type="checkbox"/> Shoulder <input type="checkbox"/> Thigh <input type="checkbox"/> Neck <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Chest <input type="checkbox"/> Hip <input type="checkbox"/> Forearm <input type="checkbox"/> Shin/Calf <input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Ankle <input type="checkbox"/> Hand <input type="checkbox"/> Foot			
20. Has the athlete ever had an eating disorder, or do you have any concerns about your eating habits or weight?			
21. Has the athlete ever been hospitalized or had surgery?			
22. Has the athlete had a medical problem or injury since their last evaluation?			
Family History			
23. Has any family member had a sudden, unexpected death before age 50 (including from sudden infant death syndrome [SIDS], car accident, drowning)?			
24. Has any family member had unexplained heart attacks, fainting, or seizures?			
25. Does the athlete have a father, mother, or brother with sickle cell disease?			

Elaborate on any positive (yes) answers:

By signing below I agree that I have reviewed and answered each question above. Every question is answered completely and is correct to the best of my knowledge. Furthermore, I give consent for this examination and give permission for my child to participate in sports.

Signature of Parent/Legal Guardian: _____ Date: _____

Signature of Athlete: _____ Date: _____

Phone Number: _____

Physical Examination (Must be Completed by a Licensed Physician, Nurse Practitioner or Physician's Assistant)

Athlete's Name _____ Age _____ Date of Birth _____

Height _____ Weight _____ BP _____ (_____ %ile) Pulse _____

Vision R 20/ _____ L 20/ _____ Corrected: Y N

These are required elements for all examinations			
	NORMAL	ABNORMAL	ABNORMAL FINDINGS
PULSES			
HEART			
LUNGS			
SKIN			
NECK/BACK			
SHOULDER			
KNEE			
ANKLE/FOOT			
Other Orthopedic Problems			

Optional Examination Elements – Should be done if history indicates

HEENT			
ABDOMINAL			
GENITALIA (MALES)			
HERNIA (MALES)			

Clearance**:

A. Cleared

B. Cleared after completing evaluation/rehabilitation for:

C. Not cleared for:

Collision

Contact

Non-contact

Strenuous

Moderately Strenuous

Non-strenuous

Due to: _____

Additional Recommendations/Rehab Instructions: _____

Name of Physician/Extender: _____

Signature of Physician/Extender: _____ MD DO PA NP

(Signature and circle of designated degree required)

Date of Exam: _____

Address: _____

Phone: _____

Physician Office Stamp

** The following are considered disqualifying until appropriate medical and parental releases are obtained: post-operative clearance, acute infections, obvious growth retardation, diabetes, jaundice, severe visual or auditory impairment, pulmonary insufficiency, organic heart disease or hypertension, enlarged liver or spleen, a chronic musculoskeletal condition that limits ability for safe exercise/sport (i.e. Klippel-Feil anomaly, Sprengel's deformity), history of convulsions or concussions, absence of/ or one kidney, eye, testicle or ovary, etc.) This form approved by the North Carolina High School Athletic Association Sports Medicine Advisory Committee March 2011, and the NCHSAA Board of Directors reviewed annually.