STUDENT ATHLETIC PHYSICAL EXAMINATION

DATE: ____/____/_______

For office use:

PRINT NAME as appears in **POWERSCHOOL:**

Last Name: ____________________ First Name:__________________ Current Grade: _____

Age: ______ Date of Birth: ____/____/______ Sex: M/F Height:______ Weight _______

Family Physician:_________________________

List all medications you are currently taking: ____

Allergies: food/drink __________________ Allergies Medications: ______________________

Medical History

1. Have you ever had a concussion? Yes / No
2. Have you ever been knocked out? Yes / No
3. Have you ever injured your neck? Yes / No
4. Have you ever had an allergic reaction to an insect bite? Yes / No
5. Has your guardian or a physician ever told you that you have a heart murmur? Yes / No
6. Do you experience frequent chest pains? Yes / No
7. Have you fainted in the last 2 years? Yes / No
8. Do either of your parents have/had heart disease? Yes / No
9. Has a physician or guardian told you that you have asthma? Yes / No
10. Has a physician told you are a hemophiliac? Yes / No
11. Have you been hospitalized for any reason in the last year? Yes / No
    (give details): ____
12. Has your guardian or physician told you have epilepsy? Yes / No
13. Has your guardian or physician told you that you had a hernia? Yes / No
14. Do you have both of your kidneys? Yes / No
15. Have you had your spleen removed? Yes / No

(below to be completed by a physician)

Orthopaedic/Neurological:	**Heart/Lungs:** **Blood Pressure**: _________________ **Resting HR**:_________ **bpm**: ___________
Abdomen:	**Eyes, Ears, Nose, Throat:**

Physician's Recommendations:

____

*Above athlete: **MAY / MAY NOT** participate in athletics.

Physician's Signature:____________________________________**Date**: ____/____/_______