PRE-PARTICIPATION SPORTS PHYSICAL

Fill out this form with a parent or guardian.

Name: _____ Date of Birth: _____

Age: _____ **Grade**: _____ **Sex Assigned at Birth:** Male Female
Gender: Male Female Non-binary Transgender Female Transgender Male

School: _____

Parent/Guardian name: _____ Cell #: _____

Name of Primary Care Provider: _____ Phone: _____

Has your child had COVID-19 illness: No Yes

List all sports planned this year (even if unsure): _____

List last year's sports, if participated: _____

Any problems/injuries during last year's sports, if participated: _____

_____

Medications: None Yes: _____

Allergies (medications, food, stinging insects)**:** No Yes: _____

If yes, have you ever needed an Epi-Pen injection (either at home or at the ER?: _____

Do you have any history of major medical problems (requiring multiple doctor visits)?

No Yes: _____

Have you had any medical history of problems with organs such as the eyes, heart, lungs, kidneys, spleen, or testicles?

No Yes: _____

Do you have any history of asthma? No Yes **If yes, have you ever used/needed an inhaler?** No Yes

Does anyone in your family have asthma? No Yes: _____

Do you ever get wheezing, coughing, or shortness of breath with exercise?

No Yes: _____

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--Continue on back--

Do you have any history of heart trouble? No Yes: _____

Has anyone in your family had a heart condition or heart attack BEFORE age 50?

No Yes: _____

Does anyone in your family have RHYTHM problems with their heart, or have trouble with suddenly passing out?

No Yes: _____

Have you ever passed out during or after exercise?

No Yes: _____

Do you have pain or pressure in your chest during exercise?

No Yes: _____

Have you ever had surgery?

No Yes: _____

Have you ever had a seizure? No Yes: _____

Have you ever had a head injury or concussion? No Yes: _____

Do you have headaches with exercise? No Yes: _____

Have you ever fractured a bone in your neck or spine? No Yes: _____

Have you had any injury to a bone or joint that CONTINUES to bother you?

No Yes: _____

Has a doctor ever restricted your participation from sports in the past?

No Yes: _____

Females only: Have you started periods yet: No Yes **If yes, are they regular or irregular?** Reg Irreg

Parents: By signing this form, you declare that all of the above information is accurate to the best of your knowledge.

Parent signature: _____ Date: _____

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PRE-PARTICIPATION SPORTS PHYSICAL – PROVIDER SECTION

Height: _____ Weight: _____ BMI: _____ BP: _____ Pulse: _____

Vision: ___ Corrected ___ Uncorrected R: 20/___ L: 20/___

HEENT:	Normal	Abnormal: _____
Lungs:	Normal	Abnormal: _____
Cardiovascular:	Normal	Abnormal: _____
Abdominal:	Normal	Abnormal: _____
Hernia (Male):	Normal	Abnormal: _____
Cervical spine:	Normal	Abnormal: _____
Upper extremities:	Normal	Abnormal: _____
Thoracic/Lumbar Spine:	Normal	Abnormal: _____
Lower extremities:	Normal	Abnormal: _____

Additional notes/comments: _____

Updated: July 26, 2022

SPORTS PHYSICAL CLEARANCE FORM

Name: _____ **Date of Birth:** _____

Medications: _____

Allergies: _____

_____ Cleared for all sports without restriction.

_____ Cleared for all sports without restriction, with recommendation(s) noted below:

_____ Not cleared:

_____ For all sports.

_____ For specific sports: _____

Follow-up plan/reevaluation date: _____

Recommendations/Comments: _____

_____

_____

_____

_____

Physician name: _____

Physician signature: _____ Date: _____

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