

COMPLETE THIS FORM PRIOR TO GOING TO THE DOCTOR
PROVIDE FORM TO DOCTOR COMPLETING PHYSICAL DO NOT RETURN TO THE SCHOOL.
SPORTS PHYSICAL

Name: _____ Date of Birth: _____ Student ID: _____

Sport(s): _____ School: **Amador Valley High School** Grade: _____ Gender: _____

Fill Boxes with a Y or N. EXPLAIN YES ANSWERS BELOW. CIRCLE QUESTIONS YOU DO NOT UNDERSTAND

1. Has a doctor ever denied or restricted your participation in sports?		Infection Risk	
2. Do you have a medical condition (athsma/diabetes?)		1. Do you have a history of recurrent or persistent rashes, pressure sores, herpes or other skin infections?	
Cardiac Risk:		2. Have you ever been diagnosed or treated for a MRSA infection?	
1. Has any relative died of a heart condition suddenly before age 50?		3. History of Mono (EBV) in the last 4 weeks?	
2. Do you or your relatives have a history of:		4. History of recurrent unexplained fevers, or chronic coughing?	
a. Heart muscle disease such as hypertrophic cardiomyopathy?		5. Do you or any members of your household have a history of tuberculosis or positive PPD?	
b. Arrhythmia, irregular rhythm, pacemaker, WPW (Wolf Parkinson White), Long QT syndrome or other cardiac problem?		6. History of Hepatitis?	
c. Marfan Syndrome		7. History of HIV?	
3. Does your heart race or skip beats during exercise?		Orthopedic Risk	
4. Have you ever had chest pain during exercise?		1. Have you ever broken any bones?	
5. Have you ever passed out or nearly passed out during or after exercise?		2. History of neck or back injury?	
6. Do you have a history of high blood pressure?		3. History of chronic back or neck pain?	
7. History of a heart murmur (other than innocent murmur) or other heart problem?		4. History of ankle, knee, hip injury?	
8. History of unexplained dizziness with exercise?		5. History of wrist, elbow, shoulder injury?	
9. Have you ever had an ECG or Echocardiogram test for your heart?		6. Do you have any artificial limbs or prosthetic devices (false teeth)?	
10. History of congenital heart disease?		Other Pertinent Questions	
11. History of Carditis or Kawasaki disease?		1. Are you taking any prescription or nonprescription (over the counter) medicines or pills?	
Respiratory Risk:		2. Are you taking supplements or medications to lose weight?	
1. History of cough, wheezing or difficulty breathing during or after exercise?		3. Are you taking medications or supplements to increase your strength or improve your sports performance?	
2. Have you ever used an inhaler or taken asthma medication?		4. Are you trying to gain or lose weight?	
3. Do you have a history of severe allergies to pollens, stinging insects, foods, or grasses?		5. Were you born with or are you missing a kidney, eye, (if male testicle), (if female ovary) or other organ?	
4. Have you ever been told by a doctor that you have asthma?		6. History of bleeding or clotting disorder?	
5. History of fractured ribs in the last 6 weeks?		7. History of severe muscle cramps or feeling severely ill when exercising in the heat?	
Neurological Risk:		8. History of surgery?	
1. History of head or neck injury, or concussion?		9. History of enlarged liver or spleen?	
2. Have you ever had amnesia or memory loss after a head injury?		10. History of sickle cell disease/trait?	
3. Have you ever had numbness, tingling or weakness in your arms or legs after being hit or falling?		11. History of Hypoglycemia (low blood sugar)?	
4. History of seizures?		FEMALES OLDER THAN 16 (OPTIONAL)	
5. History of headaches with exercise?		1. Have you had no menstrual cycles?	
6. Do you have a history of any problems with your eyes or vision?		2. Have you gone more than 90 days without a period in the last 6 months?	
7. Do you wear glasses or contact lenses		EXPLAIN YES ANSWERS HERE:	
8. History of neck instability (i.e. atlantoaxial instability)			

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Athlete _____ Signature of Parent/guardian _____ Date _____