Emmanuel Lutheran School

PYSICAL EXAMINATION FOR ATHLETES

Student's name _____ M/F ____ Date of Birth ___/___/____ Grade ____
Last, First, MI

Address _____ Student Resides With _____
Street NO. City State Zip Code

Mother/Guardian's Name _____ Cell Number _____

Father/Guardian's Name _____ Cell Number _____

Emergency Contact #1 _____ Cell Number _____
Name & Relationship

Emergency Contact #2 _____ Cell Number _____
Name & Relationship

Health and/or Insurance Carrier _____ Policy Number _____

The student and parent/guardian consent and authorize school officials, qualified coach/staff, or physician as determined by the school, to provide any first aid and/or emergency care as well as follow-up first aid or medical treatment that may be reasonably necessary for the student as determined by a school official in the course of athletic practice, competition, or travel.

The student and parent/guardian hereby consent to the release of medical information by physician to school to obtain information regarding the medical history, records of injury or surgery, serious illness, and rehabilitation results of the student from his/her physician(s). This information is confidential and except as provided in this release will not otherwise released by the parents in charge of the information. This release remains valid until revoked by the parent or guardian in writing.

Signature of Student_____Signature of Parent/Guardian_____Date_____

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TO BE COMPLETED BY PHYSICIAN ONLY

Height _____ feet & inches Weight ____ lbs Blood pressure _____/____ Pulse _____ BPM

Vision: R 20/____ L 20/____ Corrected: Yes / No Pupils: Equal ____ Unequal ____

Asthma: _____(medications used) Diabetes _____(medications used) Allergies_____ (medications used)

MEDICAL	NORMAL	COMMENTS	INITIALS
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart/murmurs			
Pulses			
Lungs			
Abdomen			
Skin			
Genitalia			
MUSCULOSKELETAL			
Neck			
Back/Spine			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Calf/ankle			
Foot/toes			
Other			

(over)

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Parent/Guardian and Student to fill out before Physical Examination

Explain "Yes" answers below. Circle question you don't know the answer to.

		Yes	No
1.	Has a doctor ever denied or restricted your participation in sports for any reason?	❑	❑
2.	Do you have an ongoing medical condition (like diabetes or asthma)?	❑	❑
3.	Are you currently taking any prescription or nonprescription (over the counter) medicines or pills?	❑	❑
4.	Do you have allergies to medicines, pollens, foods or stinging insects?	❑	❑
5.	Have you ever passed out or nearly passed out DURING exercise?	❑	❑
6.	Have you ever passed out or nearly passed out AFTER exercise?	❑	❑
7.	Have you ever had discomfort, pain or pressure in your chest during exercise?	❑	❑
8.	Does your heart race or skip beats during exercise?	❑	❑
9.	Has a doctor ever told you that you have: (circle all that apply) High blood pressure A heart murmur High Cholesterol A heart infection	❑	❑
10.	Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)	❑	❑
11.	Has anyone in your family died for no apparent reason?	❑	❑
12.	Does anyone in your family have a heart problem?	❑	❑
13.	Has any family member or relative died of heart problems or of sudden death before age 50?	❑	❑
14.	Has a family member died while exercising?	❑	❑
15.	Does anyone in your family have Marfan Syndrome?	❑	❑
16.	Have you ever spent the night in a hospital?	❑	❑
17.	Have you ever had surgery?	❑	❑
18.	Have you ever had an injury, like sprain, muscle or ligament tear, or tendonitis, that caused you to miss a practice or game? If yes, list affected area: _____	❑	❑
19.	Have you had any broken or fractured bones or dislocated joints? If yes, list affected area: _____	❑	❑
20.	Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, list affected area: _____	❑	❑
21.	Have you ever had a stress fracture?	❑	❑
22.	Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	❑	❑
23.	Do you regularly use a brace or assistive device?	❑	❑
24.	Has a doctor ever told you that you have asthma or wheezing?	❑	❑
	EXPLAIN "YES" answers here: **(Add additional pages if necessary)**		

		Yes	No
25.	Do you cough, wheeze or have difficulty breathing during or after exercise?	❑	❑
26.	Have you ever used an inhaler or taken asthma medicine?	❑	❑
27.	Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	❑	❑
28.	Have you had infectious mononucleosis (mono) within the last month?	❑	❑
29.	Do you have any rashes, pressure sores, or other skin problems?	❑	❑
30.	Have you had a herpes skin infection?	❑	❑
31.	Have you ever had a head injury or concussion?	❑	❑
32.	Have you been hit in the head and been confused or lost your memory?	❑	❑
33.	Have you ever had a seizure?	❑	❑
34.	Do you have headaches with exercise?	❑	❑
35.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	❑	❑
36.	Have you ever been unable to move your arms or legs after being hit or falling?	❑	❑
37.	When exercising in the heat, do you have severe muscle cramps, or become ill?	❑	❑
38.	Do you have any hearing problems?	❑	❑
39.	Do you have a hearing device?	❑	❑
40.	Do you have a family member with hearing problems?	❑	❑
41.	Has a doctor told you that you, or does someone in your family have sickle cell trait or sickle cell disease?	❑	❑
42.	Have you bad any problems with your eyes or vision?	❑	❑
43.	Do you wear glasses or contact lenses?	❑	❑
44.	Do you wear protective eyewear, such as goggles or a face shield?	❑	❑
45.	Are you happy with your weight?	❑	❑
46.	Would you like to lose weight?	❑	❑
47.	Would you like to gain weight?	❑	❑
48.	Has anyone recommended you change your weight or eating habits?	❑	❑
49.	Do you limit or carefully control what you eat?	❑	❑
50.	Do you have any concerns that you would like to discuss with a doctor?	❑	❑
51.	Do you feel depressed?	❑	❑
52.	Do you have a history of multiple or long nosebleeds?	❑	❑
53.	**MALES ONLY:** Do you ever have or had swelling of your testicles or groin?	❑	❑
	FEMALES ONLY		
54.	Have you ever had a menstrual period?	❑	❑
55.	How many periods have you had in the last 12 months?	____	

I hereby verify to the best of my knowledge that the answers which have been provided to the above questions are correct.

Signature of Student_____ Signature of Parent/Guardian _____Date _____

Clearance: (Place a check in appropriate box below)

- ❑ Cleared for all sports
- ❑ Cleared after completing evaluation/rehabilitation for _____
- ❑ Not cleared for:
  - ❑ Collision (Football)
  - ❑ Contact (Baseball, Basketball, Cheerleading, Judo, Softball, Soccer, Volleyball, Wrestling)
  - ❑ Non contact ❑ Strenuous ❑ Moderately Strenuous ❑ Non-strenuous

Reason not cleared: _____

Physician's Recommendation _____

Name of Physician _____ **Date of Physical Exam**_____

Address _____ **Telephone** _____

Signature of Physician _____ **Fax Number** _____