Hilltop Christian School

Sports Physical Form

Name:_____ Gender: M F Date of Birth:_____

Father's Name:_____ Phone:_____

Mother's Name:_____ Phone: _____

Street Address:_____

City:_ _____ State: _____ Zip Code: _____

Alternate Emergency Contact: _____ Phone: _____

Please indicate Medical Alerts such as allergic reactions, contact lenses, etc:_____

Medical History

Athletes and parents: This health record is a critical element in the determination of an athlete's risk of injury in sports. Please take the time to read & answer all questions before seeing a physician for the athlete's physical examination.

1. Has anyone in the athlete's family died suddenly before age 50? Yes No
2. Has the athlete ever stopped exercising because of dizziness or passed out during exercise? Yes No
3. Does the athlete have asthma (wheezing), hay fever, or coughing spells after exercise? Yes No
4. Has the athlete ever had a broken bone or any injury to any joint? Yes No
5. Does the athlete have a history of concussions? Yes No
6. Has the athlete ever suffered a heat-related illness (heat stroke)? Yes No
7. Does the athlete have a chronic illness or see a dr. regularly for a particular problem? Yes No
8. Does the athlete take any medication(s)? Yes No
9. Is the athlete allergic to any medications or bee stings? Yes No
10. Does the athlete have only one of any paired organs? (eyes, ears, kidneys, testicles, ovaries)? Yes No
11. Has the athlete had an injury in the last year that caused the athlete to miss practices 3xor more? Yes No
12. Has the athlete had surgery or been hospitalized in the past yr? Yes No
13. Are you, the athlete, worried about any problem or condition at this time? Yes No

Please give details on any "yes" answer from the above health history.

_____
_____
_____
_____

Physical Exam – to be completed by Physician

Height_____ Weight _____ Pulse _____ BP _____

	Normal	Abnormal Findings	Initials
Eyes			
Ears, Nose, Throat			
Mouth & Teeth			
Neck			
Cardiovascular			
Chest & Lungs			
Abdomen			
Skin			
Genitalia-Hernia (male)			
Musculoskeletal: ROM, strength, etc.			
a. Neck			
b. Spine			
c. Shoulders			
d. Arms/hands			
e. Hips			
f. Thighs			
g. Knees			
h. Ankles			
i. Feet			
Neuromuscular			

Please Print/Stamp

Physician's Name_____

Street Address_____

City, State, Zip_____

Telephone_____

I certify that I have examined this athlete and found him/her medically qualified to participate in sports. I also certify that I am a licensed medical physician, physician's assistant, or family nurse practitioner. (Doctor of Chiropractic Medicine is not satisfactory.)

Physician Signature_____ Date_____

Participation Restrictions:

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