

# 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: \_\_\_\_\_

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## 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.

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|---|-----|----|
| 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 3 or 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.

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## 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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