Sports Physical Form

Athlete's Name: ____ Gender: M F Date of Birth: ___/___/___

Father's Name: ____________________________________ Daytime phone, cell phone: _________________

Mother's Name: ___________________________________ Daytime phone, cell phone: _________________

Street address: ____

City: ________________________ State: _______ Zip Code: ______________ Home phone_______________

Alternate Emergency Contact Person: _______________________ Daytime 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 and answer all questions before seeing a physician for the athlete's physical examination.

1. Has anyone in the athlete's family (grandparents, mother, father, brother, sister, aunt, uncle) died suddenly before age 50? YES NO Don't Know
2. Has the athlete ever stopped exercising because of dizziness or passed out during exercise? YES NO Don't Know
3. Does the athlete have asthma (wheezing), hay fever, or coughing spells after exercise? YES NO Don't Know
4. Has the athlete ever had a broken bone, had to wear a cast, or had an injury to any joint? YES NO Don't Know
5. Does the athlete have a history of concussion (getting knocked out)? YES NO Don't Know
6. Has the athlete ever suffered a heat-related illness (heat stroke)? YES NO Don't Know
7. Does the athlete have a chronic illness or see a doctor regularly for any particular problem? YES NO Don't Know
8. Does the athlete take any medication(s)? YES NO Don't Know
9. Is the athlete allergic to any medications or bee stings? YES NO Don't Know
10. Does the athlete have only one of any paired organs? (Eyes, ears, kidneys) YES NO Don't Know
11. Has the athlete had an injury in the last year that caused the athlete to miss 3 or more consecutive days of practice or competition? YES NO Don't Know
12. Has the athlete had surgery or been hospitalized in the past year? YES NO Don't Know
13. Has the athlete missed more than 5 consecutive days of participation in usual activities because of illness, or has the athlete had a medical illness diagnosed that has not been resolved in the past year? YES NO Don't Know
14. Are you, the athlete, worried about any problem or condition at this time? YES NO Don't Know

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

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Risk Waiver: I hereby acknowledge that athletic sports have areas of risk. I will not hold Ignite Athletics or any coaches associated with Ignite Athletics accountable for an injury sustained through normal instruction and workouts during the duration of the season.

Signature (Parent or Guardian) ____

Print Name (Parent or Guardian) ____

Date ________________________

To Be Completed By Physician:

Height __________ Weight __________ Pulse __________ Blood Pressure __________

Vision: R _____ / _____ uncorrected R _____ / _____ corrected L _____ / _____ uncorrected L _____ / _____ corrected

		Normal	Abnormal Findings	Initials
1	Eyes			
2	Ears, Nose & Throat			
3	Mouth & Teeth			
4	Neck			
5	Cardiovascular			
6	Chest & Lungs			
7	Abdomen			
8	Skin			
9	Musculoskeletal: ROM, strength, etc.			
	a. Neck			
	b. Spine			
	c. Shoulders			
	d. Arms/Hands			
	e. Hips			
	f. Thighs			
	g. Knees			
	h. Ankles			
	i. Feet			
10	Neuromuscular			

After my evaluation, I give my:

_____Full approval

_____Full approval, but needs further evaluation by Family Dentist______ Eye Doctor_____ Family Physician_____ Other_____

_____Limited approval with the following restrictions:____

_____Denial of approval for the following reasons:____

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Please Print/ Stamp

Physician's Name ____

Street Address ____

City, State, Zip Code ____

Telephone ____

Physician's Signature ____ Date _____________