WAMOGO REGIONAL HIGH SCHOOL
SPORTS PHYSICAL

Sports Physical Examination and History Form

INSTRUCTIONS AND INFORMATION - IMPORTANT PLEASE READ!

1. This form must be returned to the Health Office prior to the first practice. .
2. The Medical History section is to be completed by the student/athlete.
3. The Physical Examination section is to be completed by your health care provider.

MEDICAL HISTORY

Studentôs Name Sport (s):

Last First Middle Initial

Age: Class year: Allergies: Medications:

1. In the past have you ever had any illness or injury that:			Explain:
a) required you to stay in the hospital?	☐ No	☐ Yes	_____
b) lasted longer than 1 week (i.e. mono)?	☐ No	☐ Yes	_____
c) caused you to miss more than 3 days of practice or competition?	☐ No	☐ Yes	_____
d) is related to allergies (i.e. asthma, bee stings)?	☐ No	☐ Yes	_____
e) required an operation?	☐ No	☐ Yes	_____
f) is chronic (i.e. asthma, diabetes, heart problems, seizure disorder)?	☐ No	☐ Yes	_____
2. Do you take any prescription or over-the-counter medications or inhalers?	☐ No	☐ Yes	_____ _____
3. Has any member of your family under the age of 50 had a heart attack, heart problems or died unexpectedly?	☐ No	☐ Yes	_____
4. Have you ever been told you have a heart murmur, high blood pressure, high cholesterol or heart abnormality?	☐ No	☐ Yes	_____
5. Have you ever been restricted or denied participation in sports due to heart problems?	☐ No	☐ Yes	_____
6. Do you have asthma, exercise-induced asthma or seasonal allergies?	☐ No	☐ Yes	_____
7. Are you able to run ½ mile			
a) without stopping?	☐ No	☐ Yes	_____
b) without respiratory distress?	☐ No	☐ Yes	
8. Have you ever			
a) been dizzy or passed out during exercise?	☐ No	☐ Yes	_____
b) developed a rash or hives during exercise?	☐ No	☐ Yes	_____
c) had a head injury?	☐ No	☐ Yes	_____
d) been unconscious?	☐ No	☐ Yes	_____
e) had a concussion? (If Yes, how many? _____)	☐ No	☐ Yes	_____
f) had seizures?	☐ No	☐ Yes	_____
g) had frequent or severe headaches?	☐ No	☐ Yes	_____
9. Do you want to weigh more or less than your current weight?	☐ No	☐ Yes	_____
10. Have you ever had an eating disorder?	☐ No	☐ Yes	_____
11. Do you lose/gain weight regularly to meet weight requirements for your sport?	☐ No	☐ Yes	_____ ____
12. Do you have any current skin problems (i.e. rashes, acne, warts, itchiness)?	☐ No	☐ Yes	_____
13. Are you missing one of a paired organ (i.e. kidney, eye, testicle)?	☐ No	☐ Yes	_____
14. Have you or any of your family members been diagnosed with Marfanôs Syndrome?	☐ No	☐ Yes	_____
15. Have you had any problems with your eyes or vision?	☐ No	☐ Yes	_____
16. Do you wear any special protective or corrective devices?			
a) glasses or contacts?	☐ No	☐ Yes	_____
b) braces or retainers?	☐ No	☐ Yes	_____
c) joint braces?	☐ No	☐ Yes	_____ __
d) hearing aids?	☐ No	☐ Yes	_____
e) other devices? Please specify: _____	☐ No	☐ Yes	_____ _____

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17. **Women athletes:** Do you have regular periods?	☐ Yes	☐ No	_____ _____
18. Do you perform regular breast self examination?	☐ Yes	☐ No	
19. **Male athletes:** Do you perform regular testicular self-examination?	☐ Yes	☐ No	_____ _____
20. In the event of an acute injury or illness may we share pertinent medical information with your coaches/trainers?	☐ Yes	☐ No	
21. In the event of an acute injury or illness may we share pertinent medical information with hospital/emergency room and/or other health care providers involved in your care?	☐ Yes	☐ No	

- **Any athlete who may have experienced a significant injury or illness is required to notify Health Services.**
- **It is also the athlete's responsibility to obtain the necessary clearance from their health care provider in order to return to full sports participation following an injury or serious illness.**

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

_____ _____ _____

Signature of Athlete **Parent/Guardian if under 18 years of age** **Date**

PHYSICAL EXAMINATION

Student's Name Date of birth:

Last First Middle Initial

Vital Signs: Ht: Wt: B/P: PULSE:

Tetanus booster (date):

Visual Acuity: Uncorrected: OS _____ OD _____ OU _____

Corrected: OS _____ OD _____ OU _____

MEDICAL	Normal	Abnormal findings
Appearance		
Eyes/ears/nose/throat		
Lymph nodes		
Heart		(murmurs, irregular rhythm)
Pulses		
Lungs		
Abdomen		
Hernias		
Genitalia (males only)		
Skin		

MUSCULOSKELETAL	Normal	Abnormal findings (including ROM, DTR's, strength)
Neck		
Chest/Thorax		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand		
Hip/thigh		
Knee		
Leg/ankle		
Foot		

Comments about previous problematic joints? _____

Any physical stigmata of Marfan's Syndrome? _____

CLEARANCE: ☐ Cleared ☐ Cleared after completing evaluation/rehabilitation for: _____

_____

☐ Not cleared for: _____ Reason: _____

_____

Recommendations:_____

_____

Name of Examiner: (Print or type) : _____

Address: _____ Phone: ( ) _____

_____ Fax: ( ) _____

Your signature below implies that you have performed the physical and reviewed the Medical History provided by the patient.

Reviewed by: _____

Cleared: ☐ Yes ☐ No

F/U Needed: _____

_____

_____

Signature of examiner Title Date