Sports Physical Examination Form

Name: _____

Age: _____ Grade: _____ Gender M ❑ F ❑ School: _____

Section I

Health History (to be completed by student and parent prior to examination):

Has this student had any of the following?

Birth Defects	❑ Yes	❑ No
Chronic or recurrent illnesses	❑ Yes	❑ No
Hospitalizations	❑ Yes	❑ No
Head or neck injuries, or injuries requiring physical treatment	❑ Yes	❑ No
Surgeries	❑ Yes	❑ No
Fractures or serious musculoskeletal or joint injuries	❑ Yes	❑ No
Missing organs (eye, kidney, testicle, vision or hearing problems	❑Yes	❑ No
Allergies to medications	❑ Yes	❑ No
Problems with their heart or history of heart murmur, palpitations, rheumatic fever, Or high blood pressure	❑ Yes	❑ No
Chest pain with exercise	❑ Yes	❑ No
Asthma, wheezing with exercise, chronic cough or nighttime cough	❑ Yes	❑ No
Dizziness or fainting during or after exercise	❑ Yes	❑ No
History of seizures, concussions, loss of consciousness or frequent headaches	❑ Yes	❑ No
History of numbness, tingling, weakness in the arms or legs, or excess fatigability	❑ Yes	❑ No
Heat exhaustion or heat stroke	❑ Yes	❑ No
Firearms exposure	❑ Yes	❑ No
Difficulty with alcohol drug abuse	❑ Yes	❑ No
IV drug abuse	❑ Yes	❑ No
Dental problems	❑ Yes	❑ No
Had sex education	❑ Yes	❑ No
Mar fan's Stigmatism	❑ Yes	❑ No

Does this student:

Wear glasses, contact lenses, or dental appliances?	❑ Yes	❑ No
Take any medications?	❑ Yes	❑ No
Have a history of anemia, easy bruising or bleeding problems?	❑ Yes	❑ No

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Section II

Health History (to be completed by student and parent prior to examination):

Does this student (continued):

Have a family member who died suddenly at less than 40 years of age, other than by accident?	❑ Yes ❑ No
Have a family member who had a heart attack or sudden death while less than 50 years old?	❑ Yes ❑ No
Have a family member with asthma?	❑ Yes ❑ No
Have any moles or freckles that are growing or changing in appearance, or scar that won't heal?	❑ Yes ❑No
Use tobacco, alcohol, recreational or performance enhancing drugs?	❑Yes ❑No
Ever been excluded, or limited, from sports participation?	❑ Yes ❑ No

PERMISSION

Permission is granted for my son/daughter to participate in the above activity as conducted by Journey House Athletics Programs. I agree that if a health condition exists which would limit his/her participation in this activity; I will notify Journey House. _____

Parent and/or Guardian Signature

Section III

Physical Exam (to be completed before the exam):

VISION

Temperature: _____ Pulse: _____ Blood Pressure: _____

Height: _____ Weight: _____ Time: _____

Vision (R) without corrective lenses: _____/ _____ Vision (L) without corrective lenses: _____/ _____

Vision (R) with corrective lenses: _____/ _____ Vision (L) with corrective lenses: _____/ _____

(Print or Type)

Sports Physical Examination Form

THIS SECTION MUST BE SIGNED BY A PHYSICIAN!

Examination taken after April 1 is good for the following TWO SCHOOL YEARS.
Examination taken before April 1 is good for the remainder of that SCHOOLYEAR and the following SCHOOLYEAR.

Last Name: _____ First: _____ Middle Initial: ____
Grade: _____ Age: _____ Sex: _____
School: _____ City: _____ State: _____

The above named student has been examined and there are no apparent contraindications to participating in interscholastic athletic activities except as follows:

_____

_____

******SIGNATURE OF LICENSED PHYSICIAN**: _____
OR APNP: _____
Address: _____ City: _____ State: _____
Phone: _____ Date of Examination: _____

All students participating in interscholastic athletics must have this form on file at Journey House prior to season starting.

I hereby give my permission for the above named student to practice, compete, and represent Journey House Athletics in Journey House Athletics Programs approved interscholastic sports except those restricted on this card. I further grant permission for any medical records pertaining to the health of the above named student be made available as necessary to Journey House personnel and appropriate health care providers, including emergency medical personnel.
It is recommended that information regarding your child's allergies and prescribed medication be made available.

Signature of Parent/Guardian: _____ Date: _____