Heritage Hall Christian School SPORTS PHYSICAL

HISTORY (to be completed by student/parent) DATE:____________________

Student____Phone: (________)______________

Street__________________________________City_________________________ZIP___________

Sex:__________Age__________Date of Birth_________________________Grade_________

Personal Physician______________________________________Phone: (________)______________

Previous high school attended____

Explain "Yes" answers below: Yes No

1. Have you ever been hospitalized?.......................................[]............[]
   Have you ever had surgery: ....[]............[]
   Are you presently under a doctor's care? ....[]............[]
2. Are you presently taking any medications or pills?.......................................[]............[]
3. Do you have any allergies (medicine, bees or other stinging insects)?.......................................[]............[]
4. Have you ever passed out during or after exercise? ....[]............[]
   Have you ever been dizzy during or after exercise?.......................................[]............[]
   Have you ever had chest pain during or after exercise? ....[]............[]
   Have you ever had high blood pressure?.......................................[]............[]
   Have you ever been told that you have a heart murmur? ....[]............[]
   Have you ever had racing of your heart or skipped heartbeats? ....[]............[]
   Has anyone in your family died of heart problems or a sudden death before age 50? ....[]............[]
   Has anyone in your family had Marfan's syndrome?.......................................[]............[]
5. Do you have any skin problems (itching, rashes, acne)?.......................................[]............[]
6. Have you ever had a head injury? ....[]............[]
   Have you ever been knocked out or unconscious?.......................................[]............[]
   Have you ever had a seizure, "fit" or epilepsy? ....[]............[]
   Have you ever had a stinger, burner or pinched nerve?.......................................[]............[]
7. Have you ever had heat cramps, heat illness or muscle cramps?.......................................[]............[]
8. Do you have trouble breathing or do you cough during or after activity? ....[]............[]
9. Do you use any special equipment (pads, braces, neck rolls, eye guards, etc)?.......................................[]............[]
10. Have you had any problems with your eyes or vision? ....[]............[]
11. Are you missing an eye, kidney or testicle? ....[]............[]
12. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints? ....[]............[]
    [] Head [] Shoulder [] Thigh [] Neck [] Elbow [] Knee [] Foot
    [] Forearm [] Shin/calf [] Back [] Wrist [] Ankle [] Hip [] Hand
13. Have you had any other medical problems (infectious mononucleosis, diabetes, anemia, etc.)? ....[]............[]
14. Have you had a medical problem or injury since your last evaluation?.......................................[]............[]
15. When was your last tetanus shot?____________________________________
16. When was your first menstrual period?________________________________
    When was your last menstrual period?________________________________
    What was the longest time between your periods last year?_______________

Explain "Yes" answers:

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

Date__________________

Signature of athlete____

Signature of parent/guardian____

PHYSICAL EXAMINATION (must be signed by Physician below)

Student_____________________________________

Height____________ Weight____________ BP______/________ Pulse_____________

Vision: R 20/______ L 20/__________ Corrected: Y N Pupils (Circle): Equal/ unequal R>L L>R

	Circle (if option given)		Specific Findings
Marfan's syndrome stigmata	NO	Yes	
Heart			
Rhythm	Regular	Irregular	
Murmur (supine)	no	yes	
Murmur (standing)	no	yes	
	Normal √		Specific Findings
Lungs			
Skin			
Abdominal			
Femoral Pulses			
Genitalia/Hernia			
Musculoskeletal			
Neck			
Shoulders			
Elbows			
Wrists			
Hands			
Back			
Knees			
Ankles			
Feet			
Other			

Clearance:

A. Cleared
B. Cleared after completing evaluation/rehabilitation for:_____________________________
C. Not cleared due to:_____________________________

Recommendation:_____________________________

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I hereby certify that this athlete was examined by me. At that time no physical condition was detected which would reasonably be anticipated to render this athlete physically unfit to engage in any sport, **except those marked below.**

Boys Sports: [] Soccer [] basketball
Girls Sports: [] Volleyball [] basketball [] cheerleading

Name of Physician_____________________________

Address:_____________________________

Phone: (_______)_____________________ Date__________________

Signature of Physician_________________________ (stamp here)