LIVE OAK HIGH SCHOOL SPORTS PHYSICAL EXAMINATION EVALUATION FORM

Parent/Guardian completes the front; Physician completes the back

Name:	**Grade:**	**DOB:**	**Sex:** M F	**Date:**
Personal Physician:			**Phone:**	

Explain "YES" answers below. Circle questions for which you don't know the answer.

#	Question		
1.	Have you had a medical illness or injury since your last check up or sports physical? Do you have an ongoing chronic illness?	YES	NO
2.	Have you been hospitalized overnight in the last year?	YES	NO
3.	Have you had surgery in the last year?	YES	NO
4.	Are you currently taking any prescription medications or pills or using an inhaler?	YES	NO
5.	Have you ever taken any supplements or vitamins to help you gain or lose weight or to improve your performance?	YES	NO
6.	Do you have any allergies (for example, to pollen, medicine, food, or stinging insects?)	YES	NO
7.	Have you ever passed out during or after exercise?	YES	NO
8.	Have you ever been dizzy during or after exercise?		
9.	Have you ever had racing of your heart or skipped heartbeats?	YES	NO
10.	Have you ever had high blood pressure or high cholesterol?	YES	NO
11.	Have you ever been told you have a heart murmur?	YES	NO
12.	Has a family member or relative died of heart problems before age 50?	YES	NO
13.	Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	YES	NO
14.	Has a physician ever denied or restricted your participation in sports for any heart problems?	YES	NO
15.	Have you ever had a head injury or concussion?	YES	NO
16.	Have you ever been knocked out, become unconscious, or lost your memory?	YES	NO
17.	Have you ever had a seizure?	YES	NO
18.	Do you have frequent or severe headaches?	YES	NO
19.	Do you have asthma?	YES	NO
20.	Do you have seasonal allergies that require medical treatment?	YES	NO
21.	Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	YES	NO
22.	Have you had any problems with your eyes or vision?	YES	NO
23.	Do you wear contacts, glasses, or protective eyewear?	YES	NO
24.	Have you broken or fractured any bones or dislocated any joints in the last year?	YES	NO
25.	Have you had any problem with pain or swelling in muscles, tendons, bones or joints in the last 3 months?	YES	NO

Explain "YES" answers here:

I understand that the information provided in this questionnaire is used to ensure my safe and appropriate placement in athletic events. If required, I agree to have a medical examination, and am aware that false statements or the failure to disclose information may be sufficient to disqualify me from participation or may result in my dismissal from a team.

Signature of Athlete:	Signature of Parent/Guardian:

PHYSICAL EXAMINATION

Name:		**Date of Birth:**	
Height:	**Weight:**	**Pulse**	**Blood Pressure**

	NORMAL	**ABNORMAL FINDING**	**INITIALS**
MEDICAL			
Heart			
Pulse			
Lungs			
Abdomen			
Hernia			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wristband			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

CLEARANCE: **CLEARED** **NOT CLEARED** Reason:

Recommendations:

Name of Examiner (print) ____ Date: ____________________________

Signature of Examiner: ____