UFCA Athletic Physical Examination

HISTORY: Date of exam: _____

Name: _____ Gender: _____ Age: _____ Birth date: _____

Address: _____ Phone: _____

Grade: _____ Personal Physician: _____

Emergency Contact: _____ Phone: (H) _____ (C) _____

Relation: _____ Sports student will play: _____

This form must be completed and filed in the athletic office before student may participate in or tryout for athletics.

Check the correct box. Circle questions you don't know the answer to. Explain "Yes" answers at bottom of page.

	Yes	No
1. Have you had a medical illness or injury since your last checkup or sports physical?	___	___
2. Have you ever been hospitalized overnight?	___	___
3. Have you ever had and surgery?	___	___
4. Are you currently taking any prescription or non-prescription (OTC) medication or pills?	___	___
5. Do you have any allergies? (example-pollen, food, medicine, or stinging insects.)	___	___
6. Have you ever had a rash or hives during or after exercise or on hot days?	___	___
7. Have you ever passed out during or after exercise?	___	___
8. Have you ever had chest pain with or after exercise?	___	___
9. Have you ever been dizzy during or after exercise?	___	___
10. Do you get tired more quickly than your friends do?	___	___
11. Have you ever had racing or skipping heartbeats?	___	___
12. Have you ever had high blood pressure or cholesterol?	___	___
13. Have you ever been told that you have a heart murmur?	___	___
14. Has any family member died suddenly before age 50?	___	___
15. Has any family member had heart trouble before <50?	___	___
16. Have you had any serious viral infections (example-mononucleosis or myocarditis) within the past month?	___	___
17. Has anyone restricted your participation in sports due to any heart problems?	___	___
18. Do you have any current skin problems (example-itching, rashes, acne, warts, fungus, or blisters)?	___	___
19. Have you ever had a head injury or concussion?	___	___
20. Have you ever been knocked out, passed out, lost consciousness, or lost your memory?	___	___
21. Have you ever had a seizure?	___	___
22. Do you have frequent or severe headaches?	___	___
23. Have you ever had any numbness or tingling?	___	___
24. Have you ever had a "stinger," "burner" or pinched nerve anywhere?	___	___
25. Have you ever become ill from the heat?	___	___
26. Do you cough, wheeze, or have trouble breathing during or after activity?	___	___
27. Do you have or have you had asthma?	___	___
28. Do you have or have you had allergies that needed to be treated by a physician?	___	___
29. Do you use any protective or corrective equipment or devices that aren't usually used for your sport or position? (examples-knee brace, special neck roll, foot orthotics, retainers on your teeth, or hearing aids, etc.)	___	___
30. Have you had any problems with your eyes or vision?	___	___
31. Have you ever had a sprain, strain, or swelling after an injury?	___	___
32. Have you ever broken or fractured any bones or dislocated any joints?	___	___
33. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	___	___

____Head ____Elbow ____Thigh
____Neck ____Forearm ____Knee
____Chest ____Hand ____Ankle
____Back ____Wrist ____Shin/Calf
____Shoulder ____Finger ____Foot
____Upper arm ____Hip

(if above yes then check box and explain below)

34. Do you want to weigh more or less than you do now?	___	___
35. Do you lose weight regularly to meet weight requirements for your sport?	___	___
36. Do you feel stressed out?	___	___

37. When was your most recent vaccine (shot) for tetanus? _____

Females Only:

Have you started menstruating? ___ ___

Are you menstruating regularly? ___ ___

Explain "Yes" answers here: _____

I certify that the information on this form is correct, and I/we agree to abide by the eligibility rules and regulations governing athletics of any and all associations to which my school is a member.

Signature: _____ Signature: _____

Parent/Guardian Student

EXAMINATION

Name: _____ Date: _____

Height: _____ Weight: _____ BP: _____ P: _____ R: _____ Vision: Rt. 20/____ Left: 20/____ Both: 20/____

No correction Contacts Glasses (*Circle one*)

Body Part	Normal	Abnormal findings
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart/Pulses		
Lungs		
Abdomen		
Genitalia (Males only)		
Skin		
Neck		
Back		
Shoulder		
Arm		
Elbow		
Wrist/Hand		
Hip		
Leg		
Knee		
Ankle/Foot		

Urine: Spec. Gravity: _____ **pH:** _____ **Glucose:** _____ **Protein:** _____

Clearance:

___CLEARED WITHOUT LIMITATIONS

___ CLEARED After completing evaluation/rehabilitation for: _____

_____

___ DISQUALIFIED due to: _____

Other recommendations: _____

Signed: _____ Name/Title of Examiner: _____

Address: _____

Phone: _____ Date of Exam: _____

The following are considered disqualifying factors until medical and parental releases are obtained:
Acute infections, obvious growth problems, diabetes, jaundice, severe visual or hearing loss, pulmonary insufficiency, organic heart disease, hypertension, enlarged liver or spleen, hernia, musculoskeletal deformities or functional loss, history of convulsions or concussion, absence of one kidney or eye or testicle.

Physical is valid for one year from the date of your doctor's visit.