Name:

Physical Examination Report

Date of Physical:

Measurement and Other Findings

Height:_____ Weight: _____

1. Blood Pressure:_____ 2. Pulse:_____

3. Distant Vision:
Right 20/_____ Corr/to 20/_____
Left 20/ _____ Corr/to 20_____

4. Misc. _____
_____

Clinical Evaluation

Normal	Check each item in appropriate column; enter "NE" if not evaluated.	Abnormal	M.D. Initials
	5. **Head:** Hair, Scalp, Masses		
	6. **Eyes:** EOM's Pupils, Reflex, Lids, Conjucitivae, Scleta		
	7. **Ears:** Canals, Drums, Hearing		
	8. **Nose:** Hair, Scalp, Masses		
	9. **Mouth/Throat:** Lesions, Tonsils, Oropharynx		
	10. **Neck:** Adenopathy, Thyroid, Masses		
	11. **Lungs/Chest:** Breath sounds		
	12. **Heart:** Rhythm, Murmurs, Irregular Beat, Arm Span		
	13. **Vascular System:** Pulses, Varicosities		
	14. **Genitalia:**		

Abnormalities (list # from eval. and describe in detail):_____
_____
_____
_____
_____

Orthopedic Evaluation

Normal	Check each item in appropriate column; enter "NE" if not evaluated.	Abnormal	M.D. Initials
	15. **Neck/Back:** Strength, ROM		
	16. **Shoulder:** Strength, ROM, Laxity		
	17. **Elbow:** Strength, ROM		
	18. **Hand/Wrist:** Strength, ROM		
	19. **Knee:** Strength, ROM, Laxity		
	20. **Ankle:** Strength, ROM, Laxity		
	21. **Foot:**		
	22. **Neurologic:** Coordination, DTRS, Strength		

Abnormalities (list # from eval. and describe in detail):_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Immunizations Given Today:

___ Tdap
___ DTP/TD
___ Varicella
___ Meningitis
___ Gardasil
___ MMR
___ Hep A
___ Hep B

Final Checkout

_____ Insurance Information
_____ Clinical Exam
_____ History Complete

Examination Results

Accepted _____
Rejected _____

Explain reasons for rejection:_____
_____
_____
_____
_____
_____

The following sports are not recommended for this student athlete:_____
_____
_____
_____
_____
_____

_____
Athletic Trainer Date

_____
Physician Date

_____
Examiner Address Phone

******Please make sure medical history on other side has been completed.***

Fall Sport_____
Winter Sport_____
Spring Sport_____

Fremont Area Medical Center

Medical History & Consent Form

School

Name:_____ SS#:_____
Last *First* *MI*

Address: _____ Phone#:_____
Street

_____ Emerg#:_____
City *ST* *Zip*

Parent/Guardian:_____ Day Phone:_____

Age: _____ Birthdate:_____ Gender: M F

Grade: 6 7 8 9 10 11 12

Family Physician:_____
Name *City* *Phone*

Insurance Company:_____ Phone:_____

Name of Policy Holder:_____

Policy#:_____ Group#:_____

Emerg Contact: _____ Phone:_____ Relation:_____

The above information is needed in the event of a medical appointment or registration.

Personal History *(please fill out this side of form before Dr.'s examination)*

Circle either "Yes" or "no" for each of the following conditions which may have occurred in the past 3 years. If you answer "Yes," please clarify in the space provided (dates, specific body part(s), surgery, etc...).

Yes No Are you allergic to any medications?_____
Yes No Do you have any other allergies?_____
Yes No Do you have asthma: If yes, list medication:_____
Yes No Have you had any severe asthma attacks? (dates):_____
Yes No Are you currently taking any medications? (list):_____
Yes No Have you been "knocked out" unconscious? (dates):_____
Yes No Have you had any other head injuries?_____
Yes No Have you had any neck injuries?_____
Yes No Have you had any shoulder injuries?_____
Yes No Have you had any elbow, wrist or hand injuries?_____
Yes No Do you presently have back pain? (circle all that apply)
Seldom Occasionally Frequently With Exercise After Heavy Lifting
Yes No Are you currently receiving treatment for back problems?_____
Yes No Have you had any knee injuries?_____
Yes No Have you had any ankle or foot injuries?_____
Yes No Have you suffered any severe muscle strains?_____
Yes No Have you had any other injuries not listed above?_____
Yes No Have you been hospitalized?_____
Yes No Are you presently suffering from any illness or injury?_____
_____

CONSENT TO RELEASE MEDICAL INFORMATION

I understand that this physical is for no other purpose than to clear me for athletic participation. I understand it is not a physical for illnesses which may develop in the future. I further agree that such illnesses will be taken to the student health service, our personal doctor, or the athletic trainer for referral and care.

I give authorization to the trainer to evaluate and treat injuries that occur during my child's athletic participation. This includes immediate first aid treatment, X-ray, physical exam, follow-up care and rehabilitation. I understand the team physician has the authority to eliminate my child from further participation because of an injury and/or because of undue risk to the school. No records will be released to any one other than the attending physician unless given my written approval. I also give authorization for the trainer and coaches to discuss the injury evaluation and the rehabilitation of the injury. By signing this form, I hereby release the information to the school of my child's attendance.

_____
Parent Signature Date

Athlete will not be able to participate in athletics until this form is completed in its entirety and signed by the athlete's parents and a physician.