East Arkansas Children’s Clinic

 **Sports Physical Form**

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: M F Date of Birth: \_\_\_/\_\_\_/\_\_\_**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_ Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please indicate all MEDICAL ALERTS such as allergic reactions, contact lenses, etc:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical History:**

**Athletes and Parents: This health record is a critical element in the determination of an athlete’s risk of injury in sports:**

**Please take the time to read and answer all questions before seeing a physician for the athlete’s physical examination.**

**1. Has anyone in the athlete’s family (grandparents, mother, father, brother, sister, aunt, uncle) died suddenly before the age of 50? YES or NO**

**2. Have you ever had chest pain during or after exercise? YES or NO**

**3. Has the athlete ever stopped exercising because of dizziness or passed out during exercise? YES or NO**

**4. Does the athlete have asthma (wheezing), hay fever, or coughing spells after exercise? YES or NO**

**5. Have you ever had high blood pressure? YES or NO**

**6. Has the athlete ever had a broken bone, had to wear a cast or had an injury to any joint? YES or NO**

**7. Does the athlete have a history of concussion (getting knocked out)? YES or NO**

**8. Has the athlete ever suffered a heat-related illness (heat stroke) or muscle cramp? YES or NO**

**9. Have you ever had a seizure? YES or NO**

**10. Does the athlete have a chronic illness or see a doctor regularly for any particular problem? YES or NO**

**11. Does the athlete take any medication? YES or NO**

**12. Is the athlete allergic to any medication or bee stings? YES or NO**

**13. Has the athlete had surgery or been hospitalized in the past year? YES or NO**

**14. Are you, the athlete, worried about any problem or condition at this time? YES or NO**

**15. When was your first menstrual period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Wen was your last menstrual period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**16. When was you last tetanus shot? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please give details on any “YES” answers from above health history.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent’s signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PHYSICAL EXAM – TO BE COMPLETED BY PHYSICIAN**

**Height\_\_\_\_\_\_\_ Weight\_\_\_\_\_\_\_\_ Pulse\_\_\_\_\_\_\_\_\_\_ Blood Pressure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Vision: R\_\_\_\_\_/\_\_\_\_\_ uncorrected R\_\_\_\_\_\_/\_\_\_\_\_\_ corrected**

 **L\_\_\_\_\_/\_\_\_\_\_\_ uncorrected L\_\_\_\_\_\_/\_\_\_\_\_\_ corrected**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Normal** |  **Abnormal Findings** | **Initials** |
| **1. Eyes** |  |  |  |
| **2. Ears, Nose, Throat** |  |  |  |
| **3. Mouth and Teeth** |  |  |  |
| **4. Neck** |  |  |  |
| **5. Cardiovascular** |  |  |  |
| **6. Chest and Lungs** |  |  |  |
| **7. Abdomen** |  |  |  |
| **8. Skin** |  |  |  |
| **9. Genitalia- Hernia (male)** |  |  |  |
| **10. Musculoskeletal: ROM, Strength, ect** |  |  |  |
|  **a. neck** |  |  |  |
|  **b. spine** |  |  |  |
|  **c. shoulders** |  |  |  |
|  **d. arms/hands** |  |  |  |
|  **e. hips** |  |  |  |
|  **f. thighs** |  |  |  |
|  **g. knees** |  |  |  |
|  **h. ankles** |  |  |  |
|  **i. feet** |  |  |  |
| **11. Neuromuscular**  |  |  |  |
|  |  |  |  |

 **East Arkansas Children’s Clinic**

 **901 Holiday Drive**

 **Forrest City, Arkansas 72335**

 **870-633-0880**

**I certify that I have examined this athlete and found him/her medically qualified to participate in sports. I also certify that I am a licensed medical provider.**

**Healthcare Provider’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Participation Restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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