

RLA ATHLETIC PHYSICAL EXAM

HISTORY

Date: _____

Name: _____ Phone: (_____) _____

Address: _____ City: _____ Zip: _____

Sex: M F Age: _____ Date of Birth: _____ Grade: _____

Personal Physician: _____ Phone: (_____) _____

Previous school attended and dates: _____

Explain "Yes" answers below:

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Have you ever been hospitalized? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you presently under a doctor's care? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you presently taking any medications or pills? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have any allergies (medicine, bees, or other)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever passed out during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been dizzy during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been told you have a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had racing of your heart or skipped heartbeats? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has anyone in your family died of heart problems or a sudden death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has anyone in your family had Marfan's syndrome? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any skin problems (itching, rashes, acne)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever had a head injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been knocked out or unconscious? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a seizure, "fit" or epilepsy? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a stinger, burner or pinched nerve? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had heat cramps, heat illness or muscle cramps? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have trouble breathing or do you cough during or after activity? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you use any special equipment (pads, braces, neck rolls, eye guards, etc.)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you wear glasses or contacts or protective eye wear? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Are you missing an eye, kidney, or testicle? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints? | | |
| <input type="checkbox"/> Head | <input type="checkbox"/> | |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> | |
| <input type="checkbox"/> Thigh | <input type="checkbox"/> | |
| <input type="checkbox"/> Neck | <input type="checkbox"/> | |
| <input type="checkbox"/> Elbow | <input type="checkbox"/> | |
| <input type="checkbox"/> Knee | <input type="checkbox"/> | |
| <input type="checkbox"/> Foot | <input type="checkbox"/> | |
| <input type="checkbox"/> Forearm | <input type="checkbox"/> | |
| <input type="checkbox"/> Shin/Calf | <input type="checkbox"/> | |
| <input type="checkbox"/> Back | <input type="checkbox"/> | |
| <input type="checkbox"/> Wrist | <input type="checkbox"/> | |
| <input type="checkbox"/> Ankle | <input type="checkbox"/> | |
| <input type="checkbox"/> Hip | <input type="checkbox"/> | |
| <input type="checkbox"/> Hand | <input type="checkbox"/> | |
| 13. Have you had any other medical problems (infectious mononucleosis, diabetes, anemia, etc.)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you had a medical problem or injury since your last evaluation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. When was our last tetanus shot? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. When was your first menstrual period? | <input type="checkbox"/> | <input type="checkbox"/> |
| When was your last menstrual period? | <input type="checkbox"/> | <input type="checkbox"/> |
| What was the longest time between your periods last year? | <input type="checkbox"/> | <input type="checkbox"/> |

Explain "Yes" answers:

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

Signature of Athlete: _____

Date: _____

Signature of Parent/Guardian: _____

Date: _____

PHYSICAL EXAMINATION

Date: _____

Name: _____

Age: _____

Date of Birth _____

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: _____

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:

Sports: Baseball, Basketball, Cross Country, Football, Soccer, Track, Wrestling, Softball, Volleyball

Name of Physician: _____ Date: _____

Address: _____ Phone: (_____) _____

Signature of Physician: _____

(Based on recommendations developed by the American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine and American Osteopathic Academy of Sports Medicine.)