

RSU #22 Interscholastic Sports Physical Form



Student Name: _____ Grade: _____ Date of Birth: ____/____/____

Physician's Name: _____ Office Number: (207)- _____ - _____

PARENT: PLEASE FILL OUT COMPLETELY PRIOR TO EXAM

Student History:

	<u>Yes</u>	<u>No</u>
1. Have you ever fainted? Have you had chest pains after exercise?	_____	_____
2. Any family history of sudden death? If yes, cause? _____	_____	_____
3. Have you ever had a concussion, loss of consciousness or head injury? If yes, how many times? _____	_____	_____
4. Have you ever had heat stroke or heat exhaustion?	_____	_____
5. Do you wheeze or cough during or after exercise? Do you have a history of asthma? Do you use an inhaler?	_____	_____
6. Do you have any allergies? (medications, bee stings, food, etc.) If yes, please list _____	_____	_____
7. Any sports related injuries since last exam? If yes, list injury _____	_____	_____
8. Do you take any medications? List any prescribed and non prescribed drugs: _____ _____ _____	_____	_____
9. Have you ever been hospitalized? Have had surgery? If yes, explain _____	_____	_____
10. Indicate any of the following that you have had:		
Broken bones/stress fractures	Diabetes	
Dislocations/joint disorder	Hearing/vision impairment	
Heart murmur/palpitations	Hepatitis/Jaundice	
High blood pressure	Blood disorder	
Scoliosis	Organ absence or defect	
Seizures		
Other _____		

PHYSICIAN'S EXAMINATION:

Height: _____ Weight _____ lbs. BP: _____

Examination:	Normal	Abnormal	Comments
Lungs	_____	_____	_____
Heart/Murmurs	_____	_____	_____
Abdomen	_____	_____	_____
Genitalia	_____	_____	_____
Hernia	_____	_____	_____
Skin	_____	_____	_____

Musculoskeletal:

Neck	_____	_____	_____
Shoulder	_____	_____	_____
Elbow	_____	_____	_____
Hands	_____	_____	_____
Knees	_____	_____	_____
Quad/Hamstring	_____	_____	_____
Ankle/feet	_____	_____	_____
Back/spine	_____	_____	_____
Toe/heel/walk	_____	_____	_____
Duck walk	_____	_____	_____
Comments:	_____		

I hereby certify that this student has been found to be physically fit to participate in all school interscholastic activities based upon my review of above history and physical exam. This includes both contact and non-contact sports.

Modifications or exceptions: _____

Physician's signature: _____

Print Name: _____

Date: ____/____/____

For School Use Only:

School Nurse received: _____

Date: ____/____/____

Physical Expires on: ____/____/____

I know of no existing physical condition or additional health reason that would preclude participation in sports. I certify the answers to the above questions are true and accurate. I approve participation in athletic activities. I hereby authorize and release to the information in this document.

Parent signature: Must Sign _____ **Date:** ____/____/____