

Parks & Recreation Albemarle County Middle School SPORTS PHYSICAL FORM

(Physical is valid for 365 days)

Any questions email or call Joe Clark: jclark@albemarle.org (434) 296-5844

PHYSICAL EXAMINATION

NAME _____ Date of Birth _____ School _____

Height	Weight	<input type="checkbox"/> Male	<input type="checkbox"/> Female		
BP /	Resting Pulse	Vision R 20/	L 20/	Corrected	<input type="checkbox"/> Yes <input type="checkbox"/> No

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
Eyes/ears/nose/throat		
Lymph nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin		
Neurologic		
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional		

Medical Practitioner to School Staff (please indicate any instructions or recommendations here)

Emergency medications required on-site Inhaler Epinephrine Glucagon Other: _____

Comments:

I have reviewed the data above, reviewed his/her medical history form and make the following recommendations for his/her participation in athletics.

- CLEARED WITHOUT RESTRICTIONS**
- CLEARED WITH FOLLOWING NOTATION:** _____
- Cleared **AFTER** documented further evaluation or treatment for: _____
- Cleared for Limited participation (check and explain "reason" for all that apply): "Limited Until Date" when appropriate
 - Not cleared for (specific sports) _____ Until Date: _____
 - Reason(s): _____

NOT CLEARED FOR PARTICIPATION Reason _____

By this signature, I attest that I have examined the above student and completed this pre-participation physical including a review of Part II - Medical History.

Physician Signature: _____ (M.D., D.O., L.N.P., P.A.) Date** _____
Circle one

Examiner's Name and degree (print): _____ Phone Number _____

Address: _____ City _____ State _____ Zip _____

* Only signatures of Doctor of Medicine, Doctor of Osteopathic Medicine, Nurse Practitioner or Physician's Assistant licensed to practice in the United States will be accepted.

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MEDICAL HISTORY – Explain “Yes” answers below

This form must be completed and signed, prior to the physical examination, for review by examining practitioner. Explain “Yes” answers below with number of the question. Circle questions you don’t know the answers to.							
GENERAL MEDICAL HISTORY		Yes	No	MEDICAL QUESTIONS (cont)		Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		<input type="checkbox"/>	<input type="checkbox"/>	29. Do you have groin pain or a painful bulge or hernia in the groin area?		<input type="checkbox"/>	<input type="checkbox"/>
2. Do you currently have an ongoing medical condition? If so, Please identify: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections <input type="checkbox"/> Other:		<input type="checkbox"/>	<input type="checkbox"/>	30. Have you had mononucleosis (mono) within the last month?		<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever spent the night in the hospital?		<input type="checkbox"/>	<input type="checkbox"/>	31. Do you have any rashes, pressure sores, or other skin problems?		<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had surgery?		<input type="checkbox"/>	<input type="checkbox"/>	32. Have you ever had a herpes or MRSA skin infection?		<input type="checkbox"/>	<input type="checkbox"/>
HEART HEALTH QUESTIONS ABOUT YOU		Yes	No	33. Are you currently taking any medication on daily basis?		<input type="checkbox"/> *	<input type="checkbox"/>
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		<input type="checkbox"/>	<input type="checkbox"/>	34. Have you ever had a head injury or concussion? If so, date of last injury:		<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had discomfort, pain, or pressure in your chest during exercise?		<input type="checkbox"/>	<input type="checkbox"/>	35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		<input type="checkbox"/>	<input type="checkbox"/>
7. Does your heart race or skip beats during exercise?		<input type="checkbox"/>	<input type="checkbox"/>	36. Do you have headaches with exercise?		<input type="checkbox"/>	<input type="checkbox"/>
8. Has a doctor ever told you that you have (check all that apply): <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease <input type="checkbox"/> Other:		<input type="checkbox"/>	<input type="checkbox"/>	37. Have you ever been unable to move your arms or legs after being hit or falling?		<input type="checkbox"/>	<input type="checkbox"/>
9. Has a doctor ever ordered a test for your heart? (For ex: ECG/EKG, echocardiogram)		<input type="checkbox"/>	<input type="checkbox"/>	38. When exercising in heat, do you have severe muscle cramps or become ill?		<input type="checkbox"/>	<input type="checkbox"/>
10. Do you get lightheaded or feel more short of breath than expected during exercise?		<input type="checkbox"/>	<input type="checkbox"/>	39. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?		<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever had an unexplained seizure?		<input type="checkbox"/>	<input type="checkbox"/>	40. Have you had any other blood disorders?		<input type="checkbox"/>	<input type="checkbox"/>
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		Yes	No	41. Have you had any problems with your eyes or vision?		<input type="checkbox"/>	<input type="checkbox"/>
12. Has any family member or relative died of heart problems or had an unexpected sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		<input type="checkbox"/>	<input type="checkbox"/>	42. Do you wear glasses or contact lenses?		<input type="checkbox"/>	<input type="checkbox"/>
13. Does anyone in your family have a heart problem?		<input type="checkbox"/>	<input type="checkbox"/>	43. Do you wear protective eyewear, such as goggles or a face shield?		<input type="checkbox"/>	<input type="checkbox"/>
14. Does anyone in your family have a pacemaker or implanted defibrillator?		<input type="checkbox"/>	<input type="checkbox"/>	44. Do you worry about your weight?		<input type="checkbox"/>	<input type="checkbox"/>
15. Does anyone in your family have Marfan syndrome, cardiomyopathy, or Long Q-T?		<input type="checkbox"/>	<input type="checkbox"/>	45. Are you trying to or has any professional recommended that you try to gain or lose weight?		<input type="checkbox"/>	<input type="checkbox"/>
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		<input type="checkbox"/>	<input type="checkbox"/>	46. Do you limit or carefully control what you eat?		<input type="checkbox"/>	<input type="checkbox"/>
BONE AND JOINT QUESTIONS		Yes	No	47. Do you have any concerns that you would like to discuss with a doctor?		<input type="checkbox"/>	<input type="checkbox"/>
17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis that caused you to miss a practice or game?		<input type="checkbox"/>	<input type="checkbox"/>	48. What is the date of your last Tdap or Td(tetanus) immunization? (circle type) Date: _____			
18. Have you had any broken or fractured bones or dislocated joints?		<input type="checkbox"/>	<input type="checkbox"/>	49. Do you have an allergy to medicine, food or stinging insects?		<input type="checkbox"/>	<input type="checkbox"/>
19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches?		<input type="checkbox"/>	<input type="checkbox"/>	FEMALES ONLY			
20. Have you ever had an x-ray of your neck for atlanto-axial instability? OR Have you ever been told that you have that disorder or any neck/spine problem?		<input type="checkbox"/>	<input type="checkbox"/>	50. Have you ever had a menstrual period?		<input type="checkbox"/>	<input type="checkbox"/>
21. Have you ever had a stress fracture of a bone?		<input type="checkbox"/>	<input type="checkbox"/>	51. Age when you had your first menstrual period? _____			
22. Do you regularly use a brace or assistive device?		<input type="checkbox"/>	<input type="checkbox"/>	52. How many periods have you had in the last 12 months? _____			
23. Do you currently have a bone, muscle, or joint injury that bothers you?		<input type="checkbox"/>	<input type="checkbox"/>	EXPLAIN “YES” ANSWERS BELOW:			
24. Do any of your joints become painful, swollen, feel warm, or look red?		<input type="checkbox"/>	<input type="checkbox"/>	# _____			
25. Do you have a history of juvenile arthritis or connective tissue disease?		<input type="checkbox"/>	<input type="checkbox"/>	# _____			
MEDICAL QUESTIONS		Yes	No	# _____			
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		<input type="checkbox"/>	<input type="checkbox"/>	# _____			
27. Do you have asthma or use asthma medicine (inhaler, nebulizer)		<input type="checkbox"/>	<input type="checkbox"/>	# _____			
28. Were you born without or are you missing a kidney, an eye, a testicle, spleen or any other organ?		<input type="checkbox"/>	<input type="checkbox"/>	* List medications and nutritional supplements you are currently taking here:			

☀️ ▶️ Parent/Guardian Signature: _____ Date: _____ Athlete's Signature: _____