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:

	Yes	No
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. Circle 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:**_____/_____/_____