PHYSICAL EXAMINATION AND PARENT CONSENT FORM

This form is required to be filled out AFTER May 1st for the following school year and is valid until May 31st of the following year.

HISTORY FORM (*should be filled out by the student and **parent/guardian** PRIOR to the physical examination)*

Name **Sex** **Age** **Date of Birth**

Student ID **Grade** **School** **Sports** Owasso Athletics

Address **Phone**

Personal Physician **Phone** **Insurance Provider**

In case of emergency, contact: Name **Relationship**

Phone (H) **(C)** **(W)** **Email**

MEDICINE & ALLERGIES Please list all of the prescription and over-the-counter medicines, inhalers, and supplements (herbal and nutritional) that you are currently taking: _____

_____ ☐ **No Medications**

Do you have any allergies? ☐ **Yes** ☐ **No** **If yes, please identify specific allergy:** • **Medicines** _____

Pollens _____ • **Food**_____ • **Stinging Insects** _____

Explain "Yes" answers below in space given. Circle questions you don't know the answers to.

General Questions	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Have you had a medical condition, injury, or illness since your last check up or sports physical?		
3. Have you ever been hospitalized overnight?		
4. Do you have any ongoing medical conditions? If so, please Asthma? Anemia? Diabetes? Infections? Other?		
5. Have you ever had surgery?		
Heart Health Questions About You	**Yes**	**No**
6. Have you ever passed out DURING or AFTER exercise?		
7. Have you ever been dizzy DURING or AFTER exercises?		
8. Have you ever had discomfort, pain, or pressure in your chest during or after exercise?		
9. Do you get tired more quickly than your friends during exercises?		
10. Have you ever had racing of your heart or skipped (irregular beats) heartbeats?		
11. Do you get lightheaded or feel more short of breath than expected during exercise?		
12. Have you ever been told you have a heart murmur?		
13. Has a doctor ever ordered a test on your heart (EKG/ECG, echocardiogram)?		
14. Has your doctor ever told you that you have any heart problems? (Kawasaki disease, myocarditis, heart infection)		
15. Have you ever been told you have high blood pressure or high cholesterol?		
16. Has a physician ever denied or restricted your participation in sports for any heart problems?		
Heart Health Questions About Your Family	**Yes**	**No**
17. Has any family member or relative died of heart problems or of sudden death before the age of 50?		
18. Does anyone in your family have a heart problem?		
19. Does anyone in your family have a pacemaker or implanted defibrillator?		
20. Does anyone in your family have Marfan syndrome, cardiomyopathy, or long Q-T?		
Concussion/Head Injury Questions	**Yes**	**No**
21. Have you ever had a head injury or concussion? If yes, what was the date of the last one? _____ How many diagnosed concussions?		
22. Have you ever been knocked out, become unconcscious, or lost your memory?		
23. Do you have frequent or severe headaches?		

Medical Questions	Yes	No
24. Do you cough, wheeze,or have difficulty breathing during or after exercise?		
25. Have you ever been tested for sickle cell? If yes, please explain findings. _____		
26. Do you or does someone in your family have sickle cell trait or disease?		
27. Have you ever had a seizure or been diagnosed with a seizure disorder? If yes, what triggers your seizures? _____		
28. Were you born without or are you missing a kidney, an eye, a testicle (males), spleen, or any other organ?		
29. Do you currently have any skin problems (for example itching, rashes, acne, warts, fungus, blisters)?		
30. Do you have frequent or severe headaches?		
31. Have you ever had numbness, tingling, or weakness in your arms, hands, legs, or feet after being hit or falling?		
32. Have you had mononucleosis (mono) within the last month?		
33. Have you ever become ill or had severe muscle cramps after exercising in the heat?		
34. Do you or have you had any problems with your eyes or vision?		
35. Do you wear glasses, contacts, or protective eyewear?		
36. Do you ever worry about your weight?		
37. Do you want to weigh more or less than you do now?		
38. Do you lose weight regularly to meet weight requirements for your sport?		
39. Do you have groin pain or a painful bulge or hernia in groin area?		
40. Have you had any problems with your eyes or vision?		
41. Do you wear glasses, contact lenses, or protective eyewear?		
Bone & Joint Questions	**Yes**	**No**
42. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or game?		
43. Have you ever had any broken or fractured bones or dislocated joints?		
44. Do you regularly use braces, orthotics, or other assistive devices?		

If you answered yes for the above questions, check appropriate box and explain below.

☐ Head	☐ Shoulder	☐ Wrist	☐ Thigh	☐ Ankle
☐ Neck	☐ Upper Arm	☐ Hand	☐ Knee	☐ Foot
☐ Back	☐ Elbow	☐ Finger	☐ Shin/calf	
☐ Chest	☐ Forearm	☐ Hip		

Females Only	Yes	No
45. How old were you when you had your first menstrual period?		
46. Do you experience any problems or changes with athletic participation?		
47. How many periods have you had in the past 12 months?		

Explain "yes" answers here:

If, in the judgement of any representative of the school, the above student should need immediate care and treatment as a result of injury or sickness, I do hereby request, authorize and consent to such care and treatment as may be given said student by any physician, athletic trainer, nurse, or school representative. I do hereby agree to idemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student.

I hereby state, to the best of my (our) knowledge, my (our) answers to the above questions are complete and correct.

Parent/Guardian Signature_____ Athlete Signature _____ Date _____

PREPARTICIPATION PHYSICAL EVALUATION

DATE OF EXAM _____

Examination

Name _____ **Date of Birth**_____

Height _____ Weight _____ ☐ Male ☐ Female

Blood Pressure _____/_____ Pulse _____ Vision: R 20/ L 20/ Corrected? ☐ Yes ☐ No

Have you had an energy drink in the past 6 hours? ☐ Yes ☐ No

1. Medical	Normal	Explanation of Abnormal Findings
a.) Appearance		
b.) Eyes/Ears/Nose/Throat		
c.) Lymph Nodes		
d.) Heart		
e.) Pulses		
f.) Lungs		
g.) Abdomen		
h.) Genitourinary (males only)		
i.) Skin		
j.) Neurologic		
2. Musculoskeletal	**Normal**	**Explanation of Abnormal Findings**
a.) Neck		
b.) Back		
c.) Shoulder/Arm		
d.) Elbow/Forearm		
e.) Wrist/Hand/Fingers		
f.) Hip/Thigh		
g.) Knee		
h.) Leg/Ankle		
i.) Foot/Toes		
j.) Functional		

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

Emergency Medications Required On-Site	□ Inhaler □ Epinephrine □ Glucagon □ Other: _____
Comments:	

☐ Cleared for all sports without restriction.

☐ Cleared for all sports without restriction **with recommendations for further evaluation for treatment for:**

□ Not cleared

☐ Pending further evaluation ☐ For any sports ☐ For certain sports (please list):

Reason:

Recommendations:

Name & Title of Examiner (Print/Type) _____ Date _____

Address _____ Phone _____

Signature of Examiner _____