

CONWAY SCHOOLS PHYSICAL FORM

Name _____ Sex: **M F** Age: _____ Date of Birth: _____

Please Print

Parents Names: _____ **Grade entering in 2012-2013** _____ School _____

Physicians Name: _____

Phone: _____

Explain "YES" answers below:

	YES	NO
1. Have you ever been hospitalized?	<input type="radio"/>	<input type="radio"/>
Have you ever had surgery?	<input type="radio"/>	<input type="radio"/>
2. Are you presently taking any medication or pills?	<input type="radio"/>	<input type="radio"/>
3. Do you have any allergies (medicine, bees or other stinging insects?)	<input type="radio"/>	<input type="radio"/>
4. Have you ever passed out during or after exercise?	<input type="radio"/>	<input type="radio"/>
Have you ever been dizzy during or after exercise?	<input type="radio"/>	<input type="radio"/>
Have you ever had chest pain during or after exercise that required attention?	<input type="radio"/>	<input type="radio"/>
Do you tire more quickly than your friends during exercise?	<input type="radio"/>	<input type="radio"/>
Have you ever had High Blood pressure?	<input type="radio"/>	<input type="radio"/>
Have you ever been told that you have a heart murmur?	<input type="radio"/>	<input type="radio"/>
Have you ever had racing of your heart or skipped heartbeats?	<input type="radio"/>	<input type="radio"/>
Has anyone in your family died of Heart Problems or a sudden death before age 50?	<input type="radio"/>	<input type="radio"/>
5. Do you have any skin problems (itching, rashes, acne)?	<input type="radio"/>	<input type="radio"/>
6. Have you ever had a head injury or concussion?	<input type="radio"/>	<input type="radio"/>
Have you ever had a hit or blow to the head that caused confusion, prolonged headache and memory problems?	<input type="radio"/>	<input type="radio"/>
Have you ever been knocked out or unconscious?	<input type="radio"/>	<input type="radio"/>
Have you ever had a Seizure?	<input type="radio"/>	<input type="radio"/>
Have you ever had a stinger, burner or pinched nerve?	<input type="radio"/>	<input type="radio"/>
7. Have you ever had heat or muscle cramps?	<input type="radio"/>	<input type="radio"/>
Have you ever been dizzy or passed out in the heat?	<input type="radio"/>	<input type="radio"/>
Do you get frequent muscle cramps when exercising?	<input type="radio"/>	<input type="radio"/>
8. Do you or someone in your family have sickle cell trait or disease?	<input type="radio"/>	<input type="radio"/>
9. Do you have trouble breathing or do you cough during or after activity?	<input type="radio"/>	<input type="radio"/>
Have you ever used an inhaler or taken asthma medicine?	<input type="radio"/>	<input type="radio"/>
Is there anyone in your family who has asthma?	<input type="radio"/>	<input type="radio"/>
10. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guard, etc.)?	<input type="radio"/>	<input type="radio"/>
11. Have you had any problems with your eyes or vision?	<input type="radio"/>	<input type="radio"/>
Do you wear glasses or contacts or protective eye wear?	<input type="radio"/>	<input type="radio"/>
12. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints?	<input type="radio"/>	<input type="radio"/>
[] Head [] Shoulder [] Thigh [] Neck [] Elbow [] Hand [] Back		
[] Knee [] Foot [] Forearm [] Ankle [] Wrist [] Shin/calf [] Hip		
13. Have you had any other medical problems (infectious mononucleosis, diabetes, etc.)	<input type="radio"/>	<input type="radio"/>
14. Have you had a medical problem or injury since your last physical exam?	<input type="radio"/>	<input type="radio"/>
15. When was your last Tetanus Shot ? _____		
When was your last Measles Immunization ? _____		
16. Females Only - When was your first menstrual period? _____		
When was your last menstrual period? _____		
What was the longest time between your periods last year? _____		

Explain "YES" answers here: _____

I HEREBY STATE THAT TO THE BEST OF MY KNOWLEDGE, MY ANSWERS TO THE ABOVE QUESTIONS ARE CORRECT.

Signature of Parent/Guardian

Signature of Athlete

Date

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

Ht. _____	Wt. _____	BP: _____ / _____	Pulse: _____
Vision: R 20/ _____	L 20/ _____	Corrected Y N	Pupils _____

	NORMAL	ABNORMAL FINDING	INITIALS
Cardiopulmonary			
Pulse			
Heart			
Lungs			
Abdominal			
Genitalia			
Musculoskeletal			
Neck			
Shoulder			
Elbow			
Wrist			
Hand			
Back			
Knee			
Ankle			
Foot			
Other			

CLEARED : YES NO

NOT CLEARED DUE TO: _____

Recommendation: _____

CLEARED [AFTER] COMPLETING EVALUATION/REHABILITATION FOR: _____

Date: _____

Signature of Physician