

2006

# Player Medical History/Physical Examination



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## Player Information.

Child's Name: \_\_\_\_\_  
First Middle Last

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Grade Fall '06: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ ZIP: \_\_\_\_\_

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## Medical History.

Check any of the following illnesses or symptoms that have occurred to the player at any time since birth and explain any checks below:

- |                                      |  |  |   |
|--------------------------------------|--|--|---|
| <input type="checkbox"/> Asthma      | <input type="checkbox"/> Headaches           | <input type="checkbox"/> Heat Exhaustion | <input type="checkbox"/> Bone, Joint, Spine, Liver, Kidney, Spleen Injuries |
| <input type="checkbox"/> Allergies   | <input type="checkbox"/> Hearing Problems    | <input type="checkbox"/> Heart Problems  | <input type="checkbox"/> Glasses/Contacts                                   |
| <input type="checkbox"/> Concussions | <input type="checkbox"/> Hernia              | <input type="checkbox"/> Seizure         |   |
| <input type="checkbox"/> Diabetes    | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Organs Missing  |   |

Explanation: \_\_\_\_\_

Medications Currently Taking: \_\_\_\_\_

Any Surgeries/Hospitalizations: \_\_\_\_\_

Signature of Parent/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

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## Physical Examination.

Vitals: Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_

Normal	Abnormal	Follow-Up	Explanation if Abnormal:
<input type="checkbox"/> _____ Abdomen _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	_____
<input type="checkbox"/> _____ Chest _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	_____
<input type="checkbox"/> _____ Dental _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	_____
<input type="checkbox"/> _____ Ears/Eyes/Nose _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	_____
<input type="checkbox"/> _____ Extremities _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	_____
<input type="checkbox"/> _____ Genitalia _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	_____
<input type="checkbox"/> _____ Head _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	_____
<input type="checkbox"/> _____ Heart _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	_____
<input type="checkbox"/> _____ Ski _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	_____

I certify that I have reviewed the Medical History of player and have examined player and find them physically fit to participate in sports activities.

Signature of Physician: \_\_\_\_\_ Date: \_\_\_\_\_