ONTARIO CHRISTIAN SCHOOL – SPORTS PHYSICAL FORM

This form is required for athletic participation at Ontario Christian School.

PRE-PARTICIPATION PHYSICAL EVALUATION

Name____ Gender_____________ Date of Birth______________

Grade______________ Sport(s)____

Address____ Phone_________________________

Personal Physician / Contact____

Circle "Yes" or "No." Explain "Yes" answers below. Circle questions you don't know the answers to:

1. Have you had a medical illness or injury since your last check up or sports physical? Yes No
2. Have you ever been hospitalized overnight? Yes No
3. Are you currently taking any prescription or nonprescription medications or pills or using an inhaler? Yes No
4. Do you have allergies (i.e. to pollen, medicine, food, or stinging insects)? Yes No
5. Have you ever passed out during or after exercise? Yes No
6. Have you ever been dizzy during or after exercise? Yes No
7. Have you ever had chest pain during or after exercise? Yes No
8. Have you ever had racing of your heart or skipped heartbeats? Yes No
9. Have you had high blood pressure or high cholesterol? Yes No
10. Have you ever been told you have a heart murmur? Yes No
11. Has any family member or relative died of heart problems or of a sudden death before age 50? Yes No
12. Have you had a severe viral infection i.e. myocarditis or mononucleosis with in the last month? Yes No
13. Has a physician ever denied or restricted your participation in sports for any heart problems? Yes No
14. Do you have any current skin problems? Yes No
15. Have you ever had a head injury or concussion? Yes No
16. Have you ever been knocked out, become unconscious or lost your memory? Yes No
17. Have you ever had a seizure? Yes No
18. Do you have frequent or severe headaches? Yes No
19. Have you ever had numbness or tingling in your arms, hands, legs, or feet? Yes No
20. Have you ever had a stinger, burner, or pinched nerve? Yes No
21. Have you ever become ill from exercising in the heat? Yes No
22. Do you cough, wheeze, or have trouble breathing during or after activity? Yes No
23. Do you have asthma? Yes No
24. Do you have seasonal allergies that require medical treatment? Yes No
25. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport (i.e. knee braces, special neck roll, hearing aid, foot orthotics)? Yes No
26. Have you had any problems with your eyes or vision? Yes No
27. Have you ever had a sprain, strain, or swelling after injury? Yes No
28. Have you broken or fractured any bones or dislocated any joints? Yes No
29. Do you want to weigh more or less than you do now? Yes No
30. Do you lose weight regularly to meet weight requirements for your sport? Yes No
31. Do you feel stressed out? Yes No

FEMALES ONLY:

1. When was your first menstrual period? ___________________________
2. When was your most recent menstrual period? ____________________

Explain "Yes" answers here:

____

____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct:

____ ___________________________

Athlete Signature Date

____ ___________________________

Parent / Guardian Signature Date

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Student's Name ________________________________Grade in September_________ Date of Birth_________

Height_____________ Weight_____________ Pulse_____________ BP___________ / ___________

Vision R 20/________ L 20/________ Corrected: Yes No Pupils: Equal______ Unequal_______

	NORMAL	ABNORMAL FINDINGS
MEDICAL		
General Appearance		
Nutritional status		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		
Musculoskeletal		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand		
Hip/thigh		
Knee		
Leg/ankle/foot		

Other restrictions (if any) are: ____

____

Recommendations for additional Medical/Vision/Dental Care: ______________________________________

____

This individual is cleared to participate in any and all sports offered at Ontario Christian School.

YES_____ NO_____

PHYSICIAN'S CLEARANCE TO PARTICIPATE:

In my opinion, he/she is qualified to participate in the high school athletic program:

____________________________________ ____________________________________

Print Name of Licensed Physician Signature of Licensed Physician

____

Street City Zip

____

Telephone Fax Number Date

Make Copies of All Documents! Retain for your records!