

To be completed by physician

STAMFORD ATHLETIC PHYSICAL EXAM

Name: _____ School _____
Address _____ Sport _____
Date of Birth _____ Height _____ Weight _____ Blood Pressure (sitting) RA ____/____
Pulse _____ Vision L 20/____ R 20/____ Glasses L _____ R _____
Hearing _____ Scoliosis _____ Urinalysis _____
HBG/Hematocrit _____ Last Tetanus _____ TB Test _____

Check if Negative

| | |
|---------------------------------|-------|
| Skin | _____ |
| Pupils L ____ R ____ | _____ |
| Mouth | _____ |
| Lymphaticus: Cervical | _____ |
| Axillary | _____ |
| Chest: P.I. | _____ |
| Pulse | _____ |
| Rhythm | _____ |
| Murmurs | _____ |
| Lungs | _____ |
| Abdomen Organs | _____ |
| Genitalia: Maturation Index | _____ |
| Hernia/Scrotum | _____ |
| Orthopedic: Cervical Spine/Back | _____ |
| Scoliosis | _____ |
| Shoulders | _____ |
| Arm/Elbow/Wrist/Grip | _____ |
| Knees | _____ |
| Ankles | _____ |

“I certify that I have on this date examined this student and that, on the basis of the examination requested by the school authorities and the student’s medical history as furnished to me, I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities, except those crossed out”.

| | | | | |
|--------------|--------------|--------------|---------------|--------|
| Baseball | Basketball | Swimming | Football | Golf |
| Field Hockey | Gymnastic | Ice Hockey | Cross Country | Soccer |
| Softball | Tennis | Indoor Track | Volleyball | Track |
| Wrestling | Cheerleading | | | |

Physician:

Recommendations: _____

Explanation of any positive findings: _____

Physician _____ Date of examination _____

To be completed by Parent/Guardian

SPORTS MEDICAL HISTORY

Student Name _____

| | No | Yes |
|---|-----------|------------|
| 1. Are there any birth defects? | _____ | _____ |
| 2. Have any members of your family under age 50 had a "heart attack" or "heart problems?" | _____ | _____ |
| 3. Have you ever been told you have a heart murmur, high blood pressure, extra heart beats, or heart abnormality? | _____ | _____ |
| 4. Do you get short of breath easily or have to stop while running around a track twice (1/4 mile)? | _____ | _____ |
| 5. Are you taking any medications? If so, what? | _____ | _____ |
| 6. Have you ever had any illnesses, or condition or injury that: | | |
| a) required you to go to the hospital as a patient overnight or in the emergency room for any x-rays? | _____ | _____ |
| b) required an operation? If yes, what? | _____ | _____ |
| c) lasted longer than one week? If yes, what? | _____ | _____ |
| d) caused you to miss a game or practice? If yes, what? | _____ | _____ |
| e) is related to allergies (hives, hay fever, asthma, or medicine)? If yes, what? | _____ | _____ |
| 7. Do you bleed or bruise easily? | _____ | _____ |
| 8. Do you have any shoulder pains, elbow pains, back pains or knee pains? | _____ | _____ |

Explanation of any YES answers from above

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

Signature of Parent/Guardian

Date