Starkville-Oktibbeha Consolidated School District Physical Form

Printed Name _____ **Sex** _____ **Age** _____ **Date of Birth** _____
Grade _____ **School** _____ **Sport(s)** _____
In case of emergency, contact:
Name _____ **Relationship** _____
Phone (H) _____ **Phone (C)** _____

Circle number if "YES":

1. Have you had a medical illness or injury since your last checkup or sports physical?
2. Have you ever had surgery or have an ongoing or chronic illness?
3. Are you currently taking any prescription or nonprescription (over the counter medications or pills or using an inhaler?
4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?
5. Have you ever passed out, or been dizzy, during or after exercise?
6. Have you ever had chest pain during or after exercise?
7. Do you get tired more quickly than your friends do during exercise?
8. Have you had high blood pressure or high cholesterol?
9. Have you ever been told you have a heart murmur?
10. Has any family member or relative died of heart problems or of sudden death before the age of 50?
11. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?
12. Has a physician ever denied or restricted your participation in sports for any heart reason?
13. Have you ever had a head injury or concussion?
14. Have you ever had a seizure?
15. Do you have frequent or severe headaches?
16. Have you ever had numbness or tingling in your arms, hands, legs or feet?
17. Have you ever become ill from exercising in the heat?
18. Do you cough, wheeze, or have trouble breathing during or after activity?
19. Do you have asthma?
20. Do you have seasonal allergies that require medical treatment?
21. Do you wear glasses, contacts, or protective eyewear?
22. Have you broken or fractured any bones or dislocated any joints?
23. Have you had any other problems with pain or swelling in muscles, tendons bones or joints?

Explain "Yes" Answers Here:

_____

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

_____ **Signature of Athlete**

_____ **Signature of Parent/Guardian**

_____ **Date**

Height: _____ **Weight** _____ **Pulse** _____ **Blood Pressure** ____/____, ____/____, ____/____

Medical	Normal	Abnormal	Initials
Appearance			
Eyes/Ears/Nose/Throat			
Heart			
Lungs			
Abdomen			

Musculoskeletal	Normal	Abnormal Findings	Initials
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

Check one:

_____ Cleared _____ Not Cleared

Recommendations: _____

_____, M. D. or D. O. of F.N.P. **Date of Exam:** _____
Provider Signature