

**Hickory Grove Christian School Athletic Department
Physical Evaluation**

Date _____

Name _____ Sex: M F Age _____ Grade: _____ Date of Birth _____ ID# _____

Address _____ Parents Name _____ Phone # _____

Personal Physician _____ Address _____ Phone # _____

Primary Emergency Contact _____ Relationship _____ Phone # _____

Secondary Emergency Contact _____ Relationship _____ Phone # _____

Sport(s) _____

Athlete's History

Explain "Yes" answers on top of next page:	Yes	No
1. Has your child ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>
2. Has your child ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you presently taking any medications or pills?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have any allergies (medicine, bees or other stinging insects, latex)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Has your child ever passed out DURING exercise, emotion or startle?	<input type="checkbox"/>	<input type="checkbox"/>
6. Has your child ever fainted or passed out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>
7. Has your child had extreme fatigue associated with exercise (different from other children)?	<input type="checkbox"/>	<input type="checkbox"/>
8. Has your child ever had unusual or extreme shortness of breath during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
9. Has your child ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
10. Has your child ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
11. Has your child ever been diagnosed with an unexplained seizure disorder or exercise-induced asthma?	<input type="checkbox"/>	<input type="checkbox"/>
12. Has a doctor ever told you that your child has high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
13. Has a doctor ever told you that your child has high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>
14. Has a doctor ever told you that your child has a heart infection?	<input type="checkbox"/>	<input type="checkbox"/>
15. Has a doctor ever ordered a test for your child's heart?	<input type="checkbox"/>	<input type="checkbox"/>
16. Has a doctor ever told your child has a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
17. Has your child ever had discomfort, pain, or pressure in his chest during exercise or complained of his heart "racing" or "skipping beats"?	<input type="checkbox"/>	<input type="checkbox"/>
18. Do you have any skin problems (itching, rashes, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
19. Have you ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you ever been knocked out or unconscious?	<input type="checkbox"/>	<input type="checkbox"/>
21. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
22. Have you ever had a stinger, burner or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>
23. Have you ever had heat or muscle cramps?	<input type="checkbox"/>	<input type="checkbox"/>
24. Have you ever been dizzy or passed out in the heat?	<input type="checkbox"/>	<input type="checkbox"/>
25. Do you have trouble breathing or do you cough during or after activity?	<input type="checkbox"/>	<input type="checkbox"/>
26. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guard, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
27. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
28. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injury of any bones or joints?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Head <input type="checkbox"/> Shoulder <input type="checkbox"/> Thigh <input type="checkbox"/> Neck <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Chest <input type="checkbox"/> Hip <input type="checkbox"/> Forearm <input type="checkbox"/> Shin/calf <input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Ankle <input type="checkbox"/> Hand <input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>
29. Have you ever had an eating disorder, or do you have any concerns about your eating habits or weight?	<input type="checkbox"/>	<input type="checkbox"/>
30. Do you have any chronic medical illnesses (diabetes, asthma, kidney problems, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
31. Have you had a medical problem or injury since your last evaluation?	<input type="checkbox"/>	<input type="checkbox"/>
32. Do you take any supplements? If so, list.	<input type="checkbox"/>	<input type="checkbox"/>
33. When was your last tetanus shot? _____	<input type="checkbox"/>	<input type="checkbox"/>
34. When was your last measles immunization? _____	<input type="checkbox"/>	<input type="checkbox"/>
Family History	<input type="checkbox"/>	<input type="checkbox"/>
Has any family member had a sudden, unexpected, unexplained death before age 50 (including from sudden infant death syndrome [SIDS], car accident, drowning)?	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone in your family died suddenly of heart problems before age 50?	<input type="checkbox"/>	<input type="checkbox"/>
Has any family member had unexplained fainting or seizures?	<input type="checkbox"/>	<input type="checkbox"/>
Do any relatives have a heart condition, such as:	<input type="checkbox"/>	<input type="checkbox"/>
Hypertrophic cardiomyopathy (Enlarged Heart)	<input type="checkbox"/>	<input type="checkbox"/>
Dilated cardiomyopathy	<input type="checkbox"/>	<input type="checkbox"/>
Aortic rupture or Marfan syndrome or Ehlers-Danlos syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Coronary artery atherosclerotic disease (heart attack, age 50 yrs. or younger)	<input type="checkbox"/>	<input type="checkbox"/>
Arrhythmogenic right ventricular cardiomyopathy	<input type="checkbox"/>	<input type="checkbox"/>
Long QT syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Short QT syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Brugada syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Catecholaminergic ventricular tachycardia	<input type="checkbox"/>	<input type="checkbox"/>
Primary pulmonary hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker or implanted cardiac defibrillator	<input type="checkbox"/>	<input type="checkbox"/>
Congenital deafness (deaf at birth)	<input type="checkbox"/>	<input type="checkbox"/>

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 all "Yes" answers on History Section (previous page): _____

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

Date _____ Signature of Athlete _____ Signature of Parent/Guardian _____

Physical Examination (Completed by a Duly Licensed Physician, Nurse Practitioner or Physician's Assistant)

Athlete's Name _____ Age _____ Date of Birth _____

Height _____	Weight _____	BP _____ (_____ % ile) / _____ (_____ % ile)	Pulse _____
Vision R 20/ _____	L 20/ _____	Corrected: Y N	

GENERAL	NORMAL					ABNORMAL FINDINGS					INITIALS
HEENT											
PULSES											
HEART											
LUNGS											
TANNER STAGE (Optional)	1	2	3	4	5						
SKIN											
ABDOMINAL											
GENTALIA (MALES)											
HERNIA (MALES)											

MUSCULOSKELETAL											
NECK/BACK											
SHOULDER											
ELBOW											
WRIST/HAND											
KNEE											
HIP											
ANKLE/FOOT											

Clearance:

- A. Cleared
- B. Cleared after completing evaluation/rehabilitation for : _____
- C. Not cleared for:
 - Collision
 - Contact
 - Non-contact
 - _____ Strenuous
 - _____ Moderately strenuous
 - _____ Non-strenuous

Due to: _____

Recommendation: _____

Name of Physician _____ Address _____ Date _____

Signature of Physician _____ MD DO PA NP Phone _____

Signature of Reviewing Team Physician _____ Date _____

(The following are considered disqualifying until medical and parental releases are obtained: acute infections, obvious growth retardation, diabetes, jaundice, severe visual or auditory impairment, pulmonary insufficiency, organic heart disease or hypertension, enlarged liver or spleen, hernia, musculoskeletal deformity associated with functional loss, history of convulsions or concussions, absence of one kidney, eye, testicle, or ovary, etc.)