

Sports Physical Screening Form

Sport: Football Basketball Baseball Softball Track Volleyball Cheerleading All Sports

Student Name: _____ Grade: _____ Male _____ Female _____ Date of Birth ____/____/____

Address: _____ City _____ St _____ Zip Code _____

Name of _____ Home Phone: _____

Father/Guardian: _____ Work Phone: _____ Cell Phone: _____

Name of _____

Mother/Guardian: _____ Work Phone: _____ Cell Phone: _____

Name of _____

Emergency Contact: _____ Phone Number: _____ Cell: _____

Insurance: _____ Policy Number: _____

I hereby give my consent for the above named student(son/daughter/ward) to compete in sports and to go with a representative of the school on any trips. In case of injury, you are authorized to have him/her treated.

Signature of Parent/Guardian: _____ Date: _____

Health History: To be completed by Parent/Guardian before Doctor's Exam

Any past or present	YES	NO		Yes	NO
Problems with vision			Surgeries		
Eyeglasses			Dental Problems		
Contacts			Braces		
Problems with hearing			False Teeth		
Hearing Aid			Painful Joints		
Blacking out/Fainting			Broken Bones		
Unconsciousness			Part, Date _____		
Convulsions/seizures			_____		
Heart problems			Knee or Ankle Problems		
Rheumatic fever			Require support/brace		
Bleeding disorders			Menstruation problems		
Blood sugar problems			Hernias		
Hypoglycemia			Asthma		
Diabetes			Allergies:Type _____		
Bee or insect stings			Medication: _____		
Hospitalizations					

Other health aspects the Doctor & School should be aware of: _____

Physical Exam

Date: _____

Height: _____ **Weight:** _____ **Pulse:** _____ **Resting BP:** ____/____

EYES	LYMPH NODES	POSTURE	
EARS	THYROID	MUSCLE TONE	
NOSE	HEART	REFLEXES	
THROAT	LUNGS	ORTHOPEDIC	
TEETH	ABDOMEN	SKIN	
BRACES	HERNIA	OTHER	

I have examined the above student and do recommend that he/she is physically fit for participation in sports.

Name of Physician: _____ MD or DO Date: ____/____/____

Signature: _____

Special doctor recommendations or Restrictions: _____

Children's Clinic
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