Starkville Pediatric Clinic

#5 Professional Plaza

Starkville, MS 39759

Phone (662)323-0999/ Fax (662)338-1191

Sports Physical Examination

Date: _____

Name: _____ School: _____

DOB: _____ Sex: ____ Grade: _____ Sport(s): _____

Height _____ ft _____in Weight _____ lbs. BP: _____/_____ Pulse: _____ bpm

System	WNL	Abnormal Findings	Initials
Eyes, Ears, Nose & Throat			
Cardiac/Pulses			
Lungs			
Abdominal			
Hernia (males only)			
Skin			
Neurologic			
Head/Neck			
Shoulder/Arm/ Elbow			
Wrist/Hand/Finger			
Back/Scoliosis			
Hip/Thigh			
Lower Leg/Ankle			
Foot/Toe			
Other			

Clearance: □ Full Clearance – no restrictions

□ Cleared after completing evaluation/treatment for _____

□ NOT cleared for: □ Collision/contact sports □ Strenuous activities

Special recommendations: _____

Physician Name (print) _____ Phone: (662) 323-0999

Signature: _____ Date: _____

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Date: _____

Name: _____ School: _____

DOB: _____ Sex: _____ Grade: _____ Sport(s): _____

	Questions	Yes	No
1	Have you ever been hospitalized?		
2	Have you ever had surgery?		
3	Are your immunizations up to date?		
4	Are you presently taking any medications or pills?		
5	Any known allergies (medicine, bees, or other stinging insects)?		
6	Have you ever passed out/become dizzy during or after exercise?		
7	Have you ever had chest pain during or after exercise?		
8	Do you tire more quickly than your friends during exercise?		
9	Have you ever had high blood pressure?		
10	Have you ever been told you have a heart murmur?		
11	Have you ever had a racing heart or skipped beats?		
12	Any family members died of heart problems or sudden death before age 50?		
13	Do you have any skin problems (itching, rash, acne)?		
14	Have you ever had a serious head injury?		
15	Have you ever been knocked out or unconscious?		
16	Have you ever had a seizure?		
17	Have you ever had heat or muscle cramps?		
18	Have you ever been dizzy or passed out in the heart?		
19	Do you have trouble breathing or cough during activity?		
20	Special equipment need (pads, braces, neck rolls, mouth/eye guards)?		
21	Have you had any problems with your eyes or vision?		
22	Do you wear glasses, contacts, or protective eye wear?		
23	Have you ever sprained, strained, dislocated, fractured, broken, or had repeated swelling or other injuries of any bones or joints?		
24	Any other medical problems?		
25	Have you had a medical problem/injury since the last evaluation?		

When was your last tetanus shot? _____

Explain “Yes” Answers: _____

_____

_____

_____

“I hereby state to the best of my knowledge my answers to the above questions are correct.”

Student Signature: _____

Parent/Guardian Signature: _____