Loving Municipal Schools

Athletic Participation Physical Form

Medical History-Parent/Guardian please fill out prior to examination (please use ink pen)

Athletes Name: _____, _____ _____ Upcoming Grade_____
(Please Print) Last First MI

Address_____ Phone # _____

DOB _____ Age_____ Gender: ☐ Male ☐ Female

Medical Provider: _____ Address: _____ Ph.# _____

Immunizations: ☐ Up to Date Last Tetanus Immunization: _____ ☐ Exempt

YES	NO	DON'T KNOW	Student Athlete Information
			1. Has the doctor ever denied or restricted your participation in sports for any reason?
			2. Do you have an ongoing medical condition (diabetes, asthma etc….)
			3. Do you have allergies to medicines, pollens, foods or stinging insects?
			4. Do you have wheezing, and/or coughing spells during or after exercise?
			5. Do you currently take prescription or non-prescription medicines or pills?
			6. Have you ever passed out or had to stop exercising because of dizziness?
			7. Have you had severe muscle cramps or become ill when exercising in the heat?
			8. Have you ever had a head injury or concussion? Been knocked out?
			9. Have you ever had a broken bone, had to wear a cast, or had an injury to any joint?
			10. Were you born without or are you missing any organs (eye, kidney, testicles, etc….)?
			11. Have you ever been hospitalized, or had surgery?
			12. Dou you have concerns you need to talk about to the medical provider?
Females Only:			13. Have you started your periods? ☐ Yes ☐ No
If Yes			14. How old were you when you had your first Period? _____
			15. How many periods have you had in the last 12 months? _____

Please explain "YES" answers to questions 1 through 12: _____

_____

_____

The above information is correct to the best of my knowledge.

Signature of Parent/Guardian: _____ Date: _____

Concussion Management

A concussion is a disturbance in the function of the brain that can be caused by a blow to the body or head and may occur in any sport or activity. Effects of a concussion may include a variety of symptoms (headache, nausea, dizziness, memory loss, balance problems). With or without a loss of consciousness.

I/we understand there is a concussion management protocol established that includes care and return to play criteria.

_____ _____
Student-Athlete Signature Date

_____ _____
Parent or Court Appointed Legal Guardian Signature Date

LOVING MUNICIPAL SCHOOLS

Athletic Participation Physical Evaluation Form

Athlete's Name_____ Sex_____ Age_____ Upcoming Grade_____

DOB_____ Height_____ Weight_____ Pulse_____ BP_____ / _____

Vision R – 20/_____ L – 20/_____ Corrected: ☐ Yes ☐ No Wears Contacts: ☐ Yes ☐ No

Eye Protection required while playing: ☐ Yes ☐ No

Immunizations: ☐ Up to Date Last Tetanus Immunization: _____ ☐ Exempt:

MEDICAL	Normal		Abnormal Finding/Comments
Eyes/Ears/Nose/Throat	YES	NO	
Hearing	YES	NO	
Lymph Nodes	YES	NO	
Heart	YES	NO	
Pulses	YES	NO	
Lungs: Auscultation	YES	NO	
Abdomen: (include liver, spleen)	YES	NO	
Genitourinary (males only)	YES	NO	
Skin	YES	NO	
MUSCULOSKELETAL			
Neck	YES	NO	
Back	YES	NO	
Shoulder / Arm	YES	NO	
Elbow / Forearm	YES	NO	
Wrist / Hand/ Fingers	YES	NO	
Hip / Thigh	YES	NO	
Knee	YES	NO	
Leg / Ankle	YES	NO	
Foot / Toes	YES	NO	
Flexibility / Strength	YES	NO	

Current Medical Condition: _____

Current Medications (if on asthma medication please indicate if needed prior to sport(s) _____

CLEARANCE:

_____ Student cleared for participation Limitations: _____

_____ Student cleared for participation pending evaluation/rehabilitation for: _____

_____ Student NOT cleared for participation

I hereby verify that I have reviewed this student-athlete's medical history, given the student/athlete a physical evaluation and discussed the results with the student-athlete.

Examining Provider Signature _____ ☐ MD ☐ DO ☐ DC ☐ NP ☐ PA _____
Date

Address_____ Phone_____