

NEWTOWN SCHOOL SYSTEM

SPORTS PHYSICAL EXAMINATION FORM
(TO BE COMPLETED BY FAMILY PHYSICIAN)

Date _____

Name _____ Date of birth _____ Grade _____

Address _____

H. Phone _____ B. Phone _____

Age _____ Height _____ Weight _____ BP _____ Pulse _____

HCT/HGB: _____ Urinalysis: _____ Protein _____ Glucose _____

VISION: Right: _____ Left: _____ Hearing: Normal _____ Abnormal _____

SCOLIOSIS EXAM: Neg. _____ Curvature _____ RX _____

Musculoskeletal exam: _____ Upper body _____ Lower body _____

Cardiovascular: _____ Neurological: _____

Skin: _____ Respiratory _____ TB Test: Date _____ Results _____

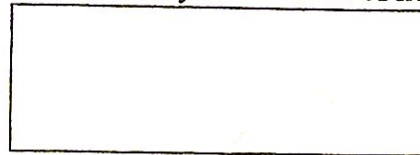
Abdomen: Liver _____ Spleen _____ Hernia _____

Immunizations: Most recent & date - DT/ _____ Td/ _____ Tdap/ _____ Adacel/ _____
Other _____

RECOMMENDATIONS:

"I certify that I have examined this student, and have found no reason which would make it medically inadvisable for this student to compete in any supervised athletic activities.

I, _____ M.D., find this child healthy and in need of no
(Print)
restrictions or care at this time.



OFFICE STAMP

Phone # _____

Date of examination: _____ Signed _____ M.D.

THIS SIDE OF FORM MUST BE COMPLETED FOR EACH INDIVIDUAL SPORT

This evaluation is only to determine readiness for sports participation. It should not be used as a substitute for regular health maintenance examinations. **PARENT & STUDENT MUST COMPLETE AND SIGN THIS SIDE BEFORE BEING BROUGHT TO THE DOCTOR'S OFFICE.**

A YEARLY PHYSICAL IS REQUIRED

Name _____ Sport _____

Please check YES or NO, if YES, explain in space at the lower portion of this page.

| | <u>YES</u> | <u>NO</u> |
|---|------------|-----------|
| 1. Have you had a medical illness or injury since your last physical? | ___ | ___ |
| 2. Do you have an ongoing or chronic illness (Asthma, Diabetes, Epilepsy, Arthritis, Hemophilia or any handicap)? | ___ | ___ |
| 3. Do you have any known allergies? Use inhaler? ___Y ___N | ___ | ___ |
| 4. Do you carry an EpiPen? | ___ | ___ |
| 5. Have you ever had a head injury/concussion or been unconscious? | ___ | ___ |
| 6. Do you wear glasses/contact lenses during play? | ___ | ___ |
| 7. Have you ever had a serious eye injury? | ___ | ___ |
| 8. Do you have false teeth/wear braces/ or need a mouth guard? | ___ | ___ |
| 9. Do you have high blood pressure, heart problems? | ___ | ___ |
| 10. Do you have a family member who had a heart attack under age 50? | ___ | ___ |
| 11. Is there any history of sudden death in your family? | ___ | ___ |
| 12. Do you have only one kidney, have a kidney disease, liver disease, or had a spleen injury? | ___ | ___ |
| 13. Do you have frequent or severe headaches? | ___ | ___ |
| 14. Do you have a hearing loss or impairment in one or both ears or had an ear injury or surgery. | ___ | ___ |
| 15. Have you ever had "mono" (mononucleosis)? Year _____ | ___ | ___ |
| 16. Have you ever had back pain/pinched nerves or a neck or spine injury? | ___ | ___ |
| 17. Have you ever had ankle, foot or knee problems including sprains or had shin splints, fractures, dislocations, or joint problems? | ___ | ___ |
| 18. Is a M.D. presently treating you? For? _____ | ___ | ___ |
| 19. Have you ever been hospitalized? Operations? _____ | ___ | ___ |
| 20. Are you currently on any long-term medication? | ___ | ___ |
| 21. Do you have any health problem or limitation which might jeopardize your participation in interscholastic sports? | ___ | ___ |

ANY YES ANSWERS, EXPLAIN HERE: _____

Our signatures indicate that we have read and understand the school's substance abuse policy.

Signature of Parent/Guardian

Signature of Student

Date

*If the physical becomes due mid season, it is the student's/parent's responsibility to get the new Sport Physical to the coach. If this is not done they will no longer be able to participate