

Physical Examination Form – Voices of Faith Athletics

DATE OF EXAM: _____

Name _____ Sex _____ Age _____ Date of Birth _____

Grade _____ School _____ Sport (s) _____

Address _____

Phone _____

Personal Physician _____

In case of emergency, contact: Name _____ Relationship _____

Phone (H) _____ (W) _____ (Cell) _____

The section below is to be completed by physician or staff after history and consent forms are completed.

Students Name _____ Birth Date _____

Height _____ Weight _____ % Body Fat (optional) _____ Pulse _____ BP _____/_____, _____/_____, _____/_____

Vision R 20/ _____ L 20/ _____ Corrected: Y N Pupils: Equal _____ Unequal _____

Follow-Up Questions on More Sensitive Issues (Optional)

- | | | |
|--|-----|----|
| 1. Do you feel stressed out or under a lot of pressure? | Yes | No |
| 2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days? | Yes | No |
| 3. Do you feel safe? | Yes | No |
| 4. Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke? | Yes | No |
| 5. During the past 30 days, did you use chewing tobacco, snuff, or dip? | Yes | No |
| 6. During the past 30 days, have you had at least 1 drink of alcohol? | Yes | No |
| 7. Have you ever taken steroid pills or shots without a doctor's prescription? | Yes | No |
| 8. Have you ever taken any supplements to help you gain or lose weight or improve your performance? | Yes | No |

Allergies: _____ Other Information: _____

MEDICAL	Normal		Abnormal findings	Initials*
Appearance	Yes	No	_____	_____
Eyes/ears/nose/throat	Yes	No	_____	_____
Hearing	Yes	No	_____	_____
Lymph nodes	Yes	No	_____	_____
Heart	Yes	No	_____	_____
Murmurs	Yes	No	_____	_____
Pulses	Yes	No	_____	_____
Lungs	Yes	No	_____	_____
Abdomen	Yes	No	_____	_____
Genitalia (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	_____	_____

Notes: _____

Physical Examination – Voices of Faith Athletics

Clearance

Cleared without restriction **Yes** **No**

Cleared, with recommendations for further evaluation or treatment for _____

Not cleared for: All Sports Certain sports: Reason: _____

Recommendations: _____

Physician Contact Information

Name of Physician: (print/type/stamp) _____ M.D., D.O., D.C.

If the Physician's Assistant (P.A.) or Advanced Nurse Practitioner (A.N.P.) performed the exam, name and address of collaborating physician or physician group: Name of Physician's Assistant (P.A.) or Advanced Nurse Practitioner (A.N.P.) _____

Name of Office: _____

Address: _____ Phone: _____

Signature: _____ Date: _____