ODYSSEY Charter School

Athletics - Sports Physical Form

Name: _____ Gender: M F Date of Birth: ___/___/___
Father's Name: _____ Daytime phone, cell phone: _____
Mother's Name: _____ Daytime phone, cell phone: _____
Street Address: _____
City: _____ St: _____ Zip: _____
Home Phone: _____
Alternate Emergency Contact Person: _____ Phone: _____
Please indicate MEDICAL ALERTS such as allergic reactions, contact lenses, etc. _____
_____

Medical History

Athletes and parents: This health record is a critical element in the determination of an athlete's risk of injury in sports. Please take the time to read and answer all questions before seeing a physician for the athlete's physical examination.

1.	Has anyone in the athlete's family (grandparent, aunt, uncle, parent, sibling) died suddenly before age 50?	YES	NO	Don't Know
2.	Has the athlete ever stopped exercising because of dizziness or passed out during exercise?	YES	NO	Don't Know
3.	Does the athlete have asthma (wheezing), hay fever or coughing spells after exercise?	YES	NO	Don't Know
4.	Has the athlete ever had a broken bone, had to wear a cast, or had an injury to any joint?	YES	NO	Don't Know
5.	Does the athlete have a history of concussion (getting knocked out)?	YES	NO	Don't Know
6.	Has the athlete ever suffered a heat-related illness (heat stroke)?	YES	NO	Don't Know
7.	Does the athlete have a chronic illness or see a doctor regularly for any particular problem?	YES	NO	Don't Know
8.	Does the athlete take any medication(s)?	YES	NO	Don't Know
9.	Is the athlete allergic to any medication or bee stings?	YES	NO	Don't Know
10.	Does the athlete have only one of any paired organs? (eyes, ears, kidneys, testicles, ovaries)	YES	NO	Don't Know
11.	Has the athlete had an injury in the last year that has caused the athlete to miss 3 or more consecutive days of practice or competition?	YES	NO	Don't Know
12.	Has the athlete had surgery or been hospitalized in the last year?	YES	NO	Don't Know
13.	Has the athlete missed more than 5 consecutive days of participation in usual activities because of illness, or has the athlete had a medical illness diagnosed that has not been resolved in the past year?	YES	NO	Don't Know
14.	Are you, the athlete, worried about any problems or conditions at this time?	YES	NO	Don't Know

Please give details on any "YES" answer from the Medical History:
_____
_____
_____

PHYSICAL EXAM-TO BE COMPLETED BY PHYSICIAN

Height: _____ Weight: _____ Pulse: _____ Blood Pressure: _____

Vision: R _____/_____ uncorrected R____/____ corrected L _____/_____ uncorrected L____/____ corrected

	Normal	Abnormal Findings	Initials
Eyes	_____	_____	_____
Ears, Nose, Throat	_____	_____	_____
Mouth and Teeth	_____	_____	_____
Neck	_____	_____	_____
Cardiovascular	_____	_____	_____
Chest and Lungs	_____	_____	_____
Abdomen	_____	_____	_____
Skin	_____	_____	_____
Genitalia-Hernia (male)	_____	_____	_____
Musculoskeletal: ROM, Strength, etc.	_____	_____	_____
a. neck	_____	_____	_____
b. spine	_____	_____	_____
c. shoulders	_____	_____	_____
d. arms/hands	_____	_____	_____
e. hips	_____	_____	_____
f. thighs	_____	_____	_____
g. knees	_____	_____	_____
h. ankles	_____	_____	_____
i. feet	_____	_____	_____
Neuromuscular	_____	_____	_____

Please Print/Stamp

Physician's Name: _____
Street Address: _____
City, State, Zip Code: _____
Telephone: _____

I certify that I have examined this athlete and found him/her medically qualified to participate in sports. I also certify that I am a licensed physician, physician's assistant, or family nurse practitioner. (Doctor of Chiropractic Medicine is not satisfactory).

Physician Signature: _____ Date: _____

PARTICIPATION RESTRICTIONS: _____
_____
_____