Legal name of student ________________________________ Graduation year 2027 ▢ 2028 ▢ 2029 ▢ 2030 ▢

First name **Last name**

2026-2027 Physical Evaluation Form

History: Completed by Parent/Guardian Date of exam: ________________

Name______________________________________ Sex ________ Age__________ Date of birth _____/_____/______
Sport(s) ____
Personal Physician __________________________________
In case of emergency, contact
Name ________________________ Relationship ______________________ Phone ______________________

Explain "Yes" answers below.

Circle questions you don't know the answers to

	Question	Yes	No
1.	Have you had a significant medical illness or injury since your last check-up or sports physical?	▢	▢
2.	Do you have an ongoing or chronic illness?	▢	▢
3.	Have you ever had surgery?	▢	▢
4.	Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?	▢	▢
5.	Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	▢	▢
6.	Have you ever passed out during or after exercise?	▢	▢
	Have you ever been dizzy during or after exercise?	▢	▢
	Have you ever had chest pain during or after exercise?	▢	▢
	Do you get tired more quickly than your friends do during exercise?	▢	▢
	Have you ever had racing of your heart or skipped heartbeats?	▢	▢
	Have you had high blood pressure? High Cholesterol?	▢	▢
	Have you ever been told you have a heart murmur?	▢	▢
	Has any family member or relative died of heart problems or of sudden death before age 35?	▢	▢
	Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	▢	▢
	Has a physician ever denied or restricted your participation in sports for any heart problems?	▢	▢
	Has a doctor ever ordered a test for your heart? (for example, ECG/EKG, echocardiogram)	▢	▢
7.	Have you or someone in your family been diagnosed with sickle cell trait or disease?	▢	▢
8.	Do you have any current skin problems (for example,itching, rashes, acne, warts, fungus, or blisters)?	▢	▢
9.	Have you ever had a head injury or concussion?	▢	▢
	Have you ever had more than one concussion if so how many?______	▢	▢
	Have you ever been diagnosed with post-concussion syndrome?	▢	▢
	Have you ever been knocked unconscious or lost your memory?	▢	▢
	Have you ever had a seizure?	▢	▢
	Do you have frequent or severe headaches or migraines?	▢	▢
	Have you ever had numbness or tingling in your arms, hands, legs, or feet?	▢	▢

	Question	Yes	No
10.	Have you ever become ill from exercising in the heat?	▢	▢
	Have ever been diagnosed with heat stroke?	▢	▢
	Do you cough, wheeze, or have trouble breathing during or after activity?	▢	▢
11.	Do you have asthma?	▢	▢
12.	Do you use any special protective or corrective equipment or devices that are not usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	▢	▢
13.	Have you had any problems with your eyes or vision?	▢	▢
	Do you wear glasses, contacts, or protective eyewear?	▢	▢
14.	Have you broken or fractured any bones or dislocated any joints?	▢	▢
	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	▢	▢
	If yes, check the appropriate box and explain below: ▢ Head/Neck ▢ UpperArm/Elbow ▢ Thigh ▢ Back/Spine ▢ Forearm/Wrist ▢ Knee ▢ Chest ▢ Hand/Fingers ▢ Shin/Calf ▢ Shoulder ▢ Hip/Pelvis ▢ Ankle/Foot		
15.	Have you ever had a stress fracture or stress reaction?	▢	▢
16.	Do you wear dental bridges, braces or plates?	▢	▢
17.	Do you have any missing organs (eye, kidney, testicle)?	▢	▢
18.	Have you ever had a hernia?	▢	▢
19.	Have you ever had an eating disorder? Worries about weight?	▢	▢
20.	(Females only) How many menstrual cycles have you had in the past 12 months?	__________	
21.	Do you have any other health concerns that you would like to discuss with your healthcare provider?	▢	▢

If you answered "yes" to any question, please explain:

____
____
____
____
____
____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of student__________________________ Signature of parent/guardian__________________________ Date_________

Physical Examination: Completed by Physician

Name ______________________________ **Date of Birth**______________________________
Height________________ **Weight**________________ **Pulse**__________ **BP** _____/_____ (_____ /_____, _____ /_____)

	Normal	Abnormal findings	Initials*
Medical			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Skin			
Musculoskeletal			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*Station-based examination only

CLEARANCE (Check all that apply)

- ▫ Cleared for physical education
- ▫ Cleared for extra-curricular sports (may include contact sports)
- ▫ Cleared after completing evaluation/rehabilitation for ______________________________

____

____

- ▫ NOT cleared for ______________________________ Reason______________________________

____

Recommendations: ______________________________

____

____

____

Name of physician (print/type/stamp)______________________________ Date of exam ________________

Address ______________________________ Phone ________________

Physician Signature ______________________________, MD, DO, PA, NP