

METROLINA CHRISTIAN ACADEMY

SPORTS PHYSICAL FORM

Part I – STUDENT INFORMATION (To Be Completed by the Student or Parent)

Student's Name: _____ Date of Birth: ____/____/____
 Age: _____ Sex: _____ Grade In School: _____ Sport(s): _____
 Parent or Guardian: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone (H): _____ Phone (W): _____ Phone (M): _____
 Emergency Contact: _____ Phone: _____
 Family Physician: _____ Phone: _____

Part II – STUDENT INFORMATION (To Be Completed by the Student or Parent)

Indicate if the student or any member of the student's family have or had the following illnesses or conditions by marking (S) for Student, (F) for Family [sibling or parent] or (B) for both in the appropriate box. Please include dates where appropriate.

Asthma		Heart Disorder	
Respiratory Disorder		Gastrointestinal Disorder	
Anemia (Including Sickle Cell)		Kidney/Genitourinary Disorder	
Hepatitis		Epilepsy or Convulsive Disorder	
Mononucleosis		Concussion number: _____	
Diabetes		Frequent or Severe Headaches	
Thyroid Disorder		History of Fainting or Dizziness	
Osteoporosis/ Osteopenia		Heart Stroke	
High Blood Pressure		Absence of Paired Organ (Eye, Kidney)	

Student's Medical:

If "Yes" to any of the above, please explain: _____

Allergies: _____

Please list any medication that you are currently taking prescription or non-prescription (over-the-counter) or using an inhaler: _____

Do you wear protective or prescription lenses, eyeglasses or contact lenses? _____

Have you ever been hospitalized? _____ Why? _____

Have you ever been denied athletic participation for medical reasons? _____ If yes, please explain: _____

Date of most recent Tetanus or Booster: _____

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Part III – ORTHOPEDIC HISTORY (To Be Completed by the Student or Parent)

Include any major musculoskeletal injury to the following areas - include sprains, dislocations, fractures and surgery.

AREA	RIGHT	LEFT	DATE	INJURY TYPE/DESCRIPTION
Foot				
Ankle				
Lower Leg				
Thigh				
Hip				
Spine				
Shoulder				
Upper Arm				
Forearm				
Wrist				
Hand				
Head				
Neck				
Other				

Do you have any other type of illness, injury or condition that is being monitored by a doctor? _____

If yes, please explain: _____

Part IV – PRE-SPORTS SCREENING (To Be Completed by a Physician)

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

Eyes: PERRLA _____ Other: _____

Heart Rhythm: NSR _____ Arrhythmia _____

Murmur: None _____ Functional _____ Other _____

Abdomen: No OMT _____ Other _____

Visual Screening:

Knee Rom/Stability Normal

Ankle Rom/Stability Normal

Neck Rom Normal

Shoulder Rom/Stability Normal

Hamstring Fingertip distance from the floor _____ inches

Scoliosis Screening: Normal _____ Other: _____

DOCTOR RECOMMENDATION:

_____ Cleared without Limitations

_____ Not Cleared REASON _____

Name of Physician (please print): _____ Phone: _____

Signature of Physician: _____ Phone: _____