

Safe Sports Network

a service of **Apple Therapy Services**

Please Read:

This sports pre-participation physical is offered FREE of charge.

Please understand that these physicals are designed specifically for sports participation and they are intended as a supplement to, rather than a substitute for, ongoing health care by a family physician or other specialist. These physicals are not designed to treat or evaluate chronic medical conditions. If your son or daughter is presently under a physician's care for any chronic medical condition, he or she must receive clearance for sports participation by that physician. Also, you must understand that there are some health conditions which cannot be detected by routine physical. If you have any concerns about your child's health, you should discuss them with your family physician or other specialist.

Physicals will be held at our office downtown, 29 Kosciuszko Street, on Thursday, June 2, 2011. **Your child should arrive between 5:30 and 6:30 p.m. on June 2, 2011** Physicals will be given on a first-come, first-served basis. This is the only available date/time for 2011. **Athletes should bathe prior to arrival and dress in shorts and T-shirt.**

Please provide the information requested on this page, and on the two inside pages of this form. It is recommended that you and your child fill out the form together in order to ensure the information given is as complete and as accurate as possible. IMPORTANT: preferred treatment will be given to pre-registered athletes. Forms signed and received at our facility by May 15 qualify for pre-registration. Walk-ins are welcome, but not recommended.

Signature of parent or guardian is required if athlete is under 18 years of age.

Last Name _____ First Name _____ MI _____

DOB _____ Age _____ Sex M F Home Phone _____

Address _____
Street City State Zip

School (next fall) _____ Grade (next fall) 6 7 8 9 10 11 12

Emergency Contact _____ Phone _____
Work Home

Last name:

First name:

School:

Medical/Injury History

Personal Physician: _____

Please answer the questions below and on the next page, explaining “yes” answers in the space provided on the next page. Circle questions if you do not know the answer.

1. Has a doctor ever denied or restricted your participation in sports for any reason? ... Yes No
2. Do you have an ongoing medical condition (like diabetes, asthma, blood clotting disease)? ... Yes No
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines, pills or inhalers? Yes No
4. Do you have allergies to medicines, pollens, foods or stinging insects?..... Yes No
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?..... Yes No
6. Have you ever had discomfort, pain or pressure in your chest during exercise?..... Yes No
7. Does your heart race or skip beats during exercise? Yes No
8. Has a doctor ever told you that you have (check all that apply):
 - High blood pressure Yes No
 - A heart murmur..... Yes No
 - High cholesterol..... Yes No
 - A heart infection..... Yes No
9. Has a doctor ever ordered a test for your heart (for example, ECG, echocardiogram)? Yes No
10. Does anyone in your family have a heart problem? Yes No
11. Has any family member or relative died of heart problems or of sudden death before age 50? Yes No
12. Has anyone in your family had unexplained fainting, seizures, or near drowning?..... Yes No
13. Does anyone in your family have Marfan syndrome? Yes No
14. Have you ever spent the night in a hospital? Yes No
15. Have you ever had surgery? Yes No

16. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis that caused you to miss a practice or game? If yes, circle the affected area below: . Yes No
17. Have you had any broken or fractured bones or dislocated joints? Have you ever had a stress fracture? If yes, Circle below: Yes No
18. Have you ever had a bone or joint injury that required x-rays, MRI, CT, surgery, Yes No injections, rehabilitation, physical therapy, a brace, a cast or crutches? If yes, Circle below:

Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand/ fingers	Chest
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/ toes

19. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?..... Yes No
20. Do you regularly use a brace or assistive device? Yes No
21. Has a doctor ever told you that you have asthma or allergies? Yes No
22. Do you cough, wheeze, or have difficulty breathing during or after exercise? Yes No
23. Is there anyone in your family who has asthma? Yes No
24. Have you ever used an inhaler or taken asthma medicine? Yes No
25. Were you born without, or are you missing, a kidney, an eye, a testicle, or any other organ? Yes No

For office use only -- do not complete this page.

Preparticipation Physical Evaluation

Name _____ Date of Birth _____

Height _____ Weight _____ Pulse _____ BP ____/____ (____/____, ____/____)

Vision R 20/____ L 20/____ Corrected Y N Pupils Equal Y N

	Normal	Abnormal Findings	Initials
Musculoskeletal			
Neck/back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
Foot			
Medical			
Appearance			
Eyes/ears/nose/throat			
Lymph nodes			
Heart/pulses/murmurs			
Lungs			
Abdomen			
Genitourinary (males)			
Skin			

NOTES _____

CLEARED _____ NOT CLEARED _____ REASON _____
RECOMMENDATIONS _____
Signature of Physician _____ Date _____