



ATHLETE PHYSICAL FORM

This is a Athlete Physical Form only. This does not substitute for the more comprehensive physical required by St. Timothy's School for all new admissions and rising 6th graders.

Athlete's Name: _____ Age: _____ Gender: _____

Parent's Directions: Please answer all questions to the best of your knowledge. If you do not understand a question, please ask your physician.

Physician's Directions: We recommend carefully reviewing these responses and clarifying with parent or legal custodian any "yes" or "don't know" responses.

Place a check in the appropriate box. Please explain below any "yes" responses.	Yes	No	Don't Know
1. Does the athlete have any chronic medical conditions (diabetes, asthma, kidney problems, etc)?			
2. Is the athlete presently taking any medications?			
3. Does the athlete have any allergies (medicine, bee stings, food, etc)?			
4. Has the athlete ever had a head injury, been knocked out, or had a concussion?			
5. Has the athlete ever had a heat related injury?			
6. Has the athlete ever passed out DURING exercise?			
7. Has the athlete ever passed out AFTER exercise?			
8. Has the athlete ever had trouble breathing during exercise?			
9. Has the athlete ever been diagnosed with exercise induced asthma?			
10. Has the athlete ever been told they have high blood pressure?			
11. Has the athlete ever been told they have a heart infection?			
12. Has the athlete ever been diagnosed with a heart murmur?			
13. Has the athlete ever complained of chest pain or pressure during or after exercise?			
14. Has the athlete ever had a seizure?			
15. Has the athlete ever had problems with their eyes or vision?			
16. Has the athlete ever sprained/strained, fractured, broken, or had repeated swelling of any bones or joints?			
17. Has the athlete ever been hospitalized or had surgery?			

Please elaborate on any "yes" responses:

By signing below, I agree that I have reviewed and answered each question to the best of my knowledge. Furthermore, as parent or legal custodian, I give consent for this examination and give permission for my child to participate in sports.

Signature of Parent/Legal Custodian: _____ **Date:** _____
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PHYSICAL EXAMINATION

(Must be completed by a licensed Physician, Nurse Practitioner, or Physician's Assistant)

Athlete's Name _____ Age: _____ DOB: _____

Height _____ Weight _____ BP _____ Pulse _____ Respirations _____

Vision R 20/ _____ L 20 / _____ Corrected? Y N

	Normal	Abnormal	Abnormal Findings
Pulses			
Heart			
Lungs			
Skin			
Neck/Back			
Shoulder			
Knee			
Ankle/Foot			
Other Orthopedic Problems			

CLEARANCE: Please **check** the appropriate line.

_____ Cleared for participation in **ALL** sports.

_____ Cleared after evaluation/rehabilitation for: _____

_____ Cleared with the **exception** of the following sports. Circle sport(s) that the athlete is **NOT CLEARED** to play:

Soccer Basketball Cheerleading Track/XC Baseball Volleyball Tennis Golf Lacrosse

_____ **NOT** Cleared for participation in sports.

Additional Recommendations/Rehab Instructions:

Name of Physician: _____

Signature of Physician: _____

Date of Exam: _____

Physician Office Stamp