School of the Incarnation
Sports Physical Form

Student's First Name:_____ Student's Last Name:_____

Gender: M F Date of Birth:_____/_____/_____

Health History: Please complete this portion prior to examination by a physician. Explain any "yes" answers in the space provided.

1.	Do you have any ongoing or chronic illnesses?	Y N	5.	Have you ever felt dizzy during or after exercise?	Y N
2.	Are you currently taking any medications?	Y N	6.	Have you ever passed out during or after exercise?	Y N
3.	Do you have any severe allergies?	Y N	7.	Have you ever had chest pain or an irregular heartbeat during or after exercise?	Y N
4.	Have you ever had a seizure or concussion?	Y N	8.	Have you ever sprained, fractured or dislocated a bone, muscle, tendon or joint?	Y N

Explain any "yes" answers here:

_____
_____
_____
_____
_____

Physician's Evaluation: Please do not complete unless questions 1-8 have been answered by the parent/guardian

Height:_____ Weight:_____ Pulse:_____ BP:_____/_____ Vision L:_____ R:_____ Corrected? Y N

Medical	**Normal**	**Abnormal Findings**
Appearance		
Eyes/Ears/Nose/Throat		
Hearing		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Skin		
Other (specify):		
Musculoskeletal	**Normal**	**Abnormal Findings**
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		

Clearance (check one of the following three options):
□ Cleared for all interscholastic sports
□ Cleared for all interscholastic sports, **except**:_____
□ **Not** cleared for interscholastic sports
Reason(s):_____
_____
_____
_____

By my signature I confirm that I have performed a pre-participation physical examination of the above-named individual and that I am qualified by training and experience to properly perform the examination and make the evaluations reflected on this form.

Signature of Physician:_____ Date:_____

Printed Name and Address or Physician's Stamp:

This form is valid for one calendar year from the date of examination.