ESYFL Physical Form

Name: _____ Gender: __M __ F Date of Birth: ___/___/___
Father's Name: _____ Daytime phone, pager, cell phone:_____
Mother's Name: _____ Daytime, phone, pager, cell phone:_____
Street address: _____
City: _____ State: _____ Zip Code: _____ Home phone: _____
Alternate Emergency Contact Person: _____ Daytime phone: _____
Please indicate MEDICAL ALERTS such as allergic reactions, contact lenses, etc.: _____
_____

Athletes and parents: This health record is a critical element in the determination of an athlete's risk of injury in sports. Please take the time to read and answer all questions before seeing a physician for the athlete's physical examination.

1. Has anyone in the athlete's family (grandparents, mother, father, brother, sister, aunt, Uncle) died suddenly before age 50? YES NO Don't Know
2. Has the athlete ever stopped exercising because of dizziness or passed out during exercise? YES NO Don't Know
3. Does the athlete have asthma (wheezing), hay fever, or coughing spells after exercise? YES NO Don't Know
4. Has the athlete ever had a broken bone, had to wear a cast, or had an injury to any joint? YES NO Don't Know
5. Does the athlete have a history of concussion (getting knocked out)? YES NO Don't Know
6. Has the athlete ever suffered a heat-related illness (heat stroke)? YES NO Don't Know
7. Does the athlete have a chronic illness or see a doctor regularly for any particular problem? YES NO Don't Know
8. Does the athlete take any medication(s)? YES NO Don't Know
9. Is the athlete allergic to any medications or bee stings? YES NO Don't Know
10. Does the athlete have only one of any paired organs? (Eyes, ears, kidneys, testicles, ovaries) YES NO Don't Know
11. Has the athlete had an injury in the last year that caused the athlete to miss 3 or more consecutive days of practice or competition? YES NO Don't Know
12. Has the athlete had surgery or been hospitalized in the past year? YES NO Don't Know
13. Has the athlete missed more than 5 consecutive days of participation in usual activities because of illness, or has the athlete had a medical illness diagnosed that has not been resolved in the past year? YES NO Don't Know
14. Are you, the athlete, worried about any problem or condition at this time? YES NO Don't Know
15. Is there any history of concussions and/or head injuries? YES NO DON'T KNOW

Please give details on any "YES" answer from the above health history.

_____
_____
_____

PHYSICAL EXAM – TO BE COMPLETED BY PHYSICIAN

Height _____ Weight _____ Pulse _____ Blood Pressure _____

Vision: R _____ / _____ uncorrected R _____ / _____ corrected L _____ / _____ uncorrected L _____ / _____

	NORMAL	ABNORMAL	INITIALS
EYES			
EARS, NOSE, THROAT			
MOUTH & TEETH			
CARDIOVASCULAR			
CHEST & LUNGS			
ABDOMEN			
SKIN			
GENITALIA-HERNIA (MALE)			
NECK			
SPINE			
SHOULDERS			
ARMS/HANDS			
HIPS			
THIGHS			
KNEES			
ANKLES			
FEET			
NEUROMUSCULAR			

Please Print/ Stamp
Physician's Name

_____

Street Address

_____

City, State, Zip Code

_____

Telephone

_____

I certify that I have examined this athlete and found him/her medically qualified to participate in sports. I also certify that I am a licensed medical physician, physician's assistant, or family nurse practitioner.

Physician Signature _____ Date _____

PARTICIPATION RESTRICTIONS:

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