

TEAM GENESIS/LOVE Swimming

A Sports Ministry of Trinity Fellowship Church Annual Sports Physical Examination Form

This Form must be completed and submitted to join the Team
(To be completed by Physician)

Date of Physical: _____ Athlete: _____

Examiner: _____
Last First Middle
=====

Date of Birth: _____ Age: _____ Sex: _____ B/P _____ Pulse: _____ Resp: _____ Temp: _____
Month-Date-Year Male/Female

Height: _____ Weight: _____ Lab: Hct: _____ U/A _____ PPD _____
Vision: R corrected _____ uncorrected _____
L corrected _____ uncorrected _____
With glasses and or contact lenses R 20/ _____ L 20/ _____ Hearing R _____ L _____

Head: _____	Eyes: _____	ENT: _____
Mouth & Teeth: _____	Neck & Soft Tissues: _____	Chest: _____
Heart: _____	Lungs: _____	Abdomen: _____
Genitalia: _____	Hernias: _____	Neurological: _____
Skin: _____	Back & Spine: _____	Joints: _____
Maturity Index: _____	Endocrine: _____	General Observations: _____

Allergies: _____

Current Medications: _____

Past History:

Operations: _____

Major Illnesses: _____

Injuries: _____

Based on this history and physical exam, the following abnormalities were found and may need treatment:

SPORTS PARTICIPATION RECOMMENDATIONS

- ☐ _____ There is no history or physical findings on this exam which would prohibit this athlete from participating in competitive athletics.
- ☐ _____ This athlete should have the following health problems evaluated or treated prior to participating in competitive athletics: _____
- ☐ _____ This athlete has health problems which would prohibit him/her from participating in competitive athletics.

Physician's Signature: _____ Date: _____

Physician's Printed Name: _____

Advanced Nurse Practitioner's Signature: _____ Date: _____

(Physician's Signature must appear also, if examination is given by a PA or Advanced Nurse Practitioner in written collaborative practice with physician).

8144 Terre Bleue Drive * P.O. Box 345 * Bonne Terre, Missouri 63628 *

Office 573-358-7727 * Fax 573-358-1909 * Cell: 573-366-0410 *

Email: chico@il.net * Web Address: <https://www.loveswimming.org>

"Love one another. As I have loved you, so you must love one another". John 13:34

TEAM GENESIS/LOVE Swimming

A Sports Ministry of Trinity Fellowship Church

ATHLETE MEDICAL HISTORY QUESTIONNAIRE

(To be completed by athlete or parent)

Name: _____ Sport: _____
Last First Middle

Address: _____
Street City State Zip

Emergency Contact: _____ Phone: (____) _____

Athlete's Doctor: _____ Phone: (____) _____

Athlete's Doctor's Address: _____
Street City State Zip

=====

Athlete or Parent is to check each box that applies and provide additional details at the end of this questionnaire.

- ☐ 1. Are you allergic to any medication (aspirin, penicillin, sulfa, etc)
- ☐ 2. Do you take any prescribed medication on a permanent or semi-permanent basis (steroids, insulin, anti – inflammatory, antibiotics, etc.)
- ☐ 3. Have you ever had an epileptic seizure?
- ☐ 4. Have you ever been told by a doctor that you have epilepsy?
- ☐ 5. Have you ever been treated for diabetes?
- ☐ 6. Have you ever been told by a doctor that you were anemic?
- ☐ 7. Have you ever been told by a doctor that you have sickle cell anemia?
- ☐ 8. Do you have or have you ever had high blood pressure?
- ☐ 9. Do you have, or have you ever had, the following diseases? Heart disease (heart murmur, rheumatic fever, other), Lung disease (pneumonia, other), Kidney disease (infections, other), Liver disease (mononucleosis, hepatitis, other).
- ☐ 10. Have you ever been told by a doctor that you have asthma?
- ☐ 11. Do you have or have you ever had a hernia or “rupture”?
- ☐ 12. Have you been “knocked out” or become unconscious in the past three years?
- ☐ 13. Have you had a concussion or other head injury in the past three years?
- ☐ 14. Have you stayed overnight in a hospital due to a head injury?
- ☐ 15. Have you ever had a neck injury involving bones, nerves, or disks that disabled you for a week or longer?
- ☐ 16. Do you wear glasses or contacts during competition?
- ☐ 17. Do you wear any of the following dental appliances: Permanent Bridge, Braces, Removable retainer, Permanent retainer, Removable partial plate, Full plate, Permanent crown or jacket.
- ☐ 18. Have you had a broken bone (fracture) in the past two years?
- ☐ 19. Have you had a shoulder injury in the past two years that disabled you for a week or longer (dislocation, separation, etc.)?
- ☐ 20. Have you ever had shoulder surgery?
- ☐ 21. Have you ever injured your back?
- ☐ 22. Do you have back pain?
- ☐ 23. Have you injured your knee in the past two years?
- ☐ 24. Have you been told by a doctor or athletic trainer that you injured the cartilage in your knee?
- ☐ 25. Have you ever had knee surgery?

CONTINUED ON NEXT PAGE

8144 Terre Bleue Drive * P.O. Box 345 * Bonne Terre, Missouri 63628 *

Office 573-358-7727 * Fax 573-358-1909 * Cell: 573-366-0410 *

Email: chico@il.net * Web Address: <https://www.loveswimming.org>

“Love one another. As I have loved you, so you must love one another”. John 13:34

TEAM GENESIS/LOVE Swimming

A Sports Ministry of Trinity Fellowship Church

ATHLETE MEDICAL HISTORY QUESTIONNAIRE CONTINUED

(To be completed by athlete or parent)

- ☐ 26. Have you had a severe ankle sprain in the past two years?
- ☐ 27. Do you have a pin, screw, or plate in your body?
- ☐ 28. Do you have any other conditions that we should be aware of (i.e., ulcers, pregnancy, food or insect allergies, tendinitis, Mental/Physical/Visual disorders, etc?)
- ☐ 29. Please give the dates of your last tetanus and polio shots: Tetanus: _____ Polio: _____

Please provide additional details for all questions checked on this Athlete Medical History Questionnaire:

Question Number:

Details:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

This Athlete Medical Questionnaire has been answered completely and truthfully to the best of my knowledge.

Signature of Athlete (or parent if athlete is a minor)

Date

CONTINUED ON NEXT PAGE

8144 Terre Bleue Drive * P.O. Box 345 * Bonne Terre, Missouri 63628 *

Office 573-358-7727 * Fax 573-358-1909 * Cell: 573-366-0410 *

Email: chico@il.net * Web Address: <https://www.loveswimming.org>

“Love one another. As I have loved you, so you must love one another”. John 13:34

TEAM GENESIS/LOVE Swimming

A Sports Ministry of Trinity Fellowship Church

Dates of Immunization

Name: _____

Address: _____ City _____ St. _____ Zip _____

Date of Birth: _____ Male _____ Female _____

Vaccine	Date Given	Physician/Clinic
---------	------------	------------------

DTP, DTAP or DT	_____	_____
-----------------	-------	-------

DT	_____	_____
----	-------	-------

OPV/IPV (polio)	_____	_____
-----------------	-------	-------

MMR	_____	_____
-----	-------	-------

HIB	_____	_____
-----	-------	-------

HEP B	_____	_____
-------	-------	-------

HEP A	_____	_____
-------	-------	-------

TD	_____	_____
----	-------	-------

MENINGOCOCCAL	_____	_____
---------------	-------	-------

PNEUMOCOCCAL CONJUGATE	_____	_____
------------------------	-------	-------

INFLUENZA	_____	_____
-----------	-------	-------

TB Date Given	_____	Date Read _____	Results _____
---------------	-------	-----------------	---------------

Allergies: _____

8144 Terre Bleue Drive * P.O. Box 345 * Bonne Terre, Missouri 63628 *

Office 573-358-7727 * Fax 573-358-1909 * Cell: 573-366-0410 *

Email: chico@il.net * Web Address: <https://www.loveswimming.org>

“Love one another. As I have loved you, so you must love one another”. John 13:34