

## CTYFL Sports Physical Form

Name: \_\_\_\_\_ Gender: M F Date of Birth: \_\_\_ / \_\_\_ / \_\_\_  
 Father's/Guardian's Name: \_\_\_\_\_ Contact Number: \_\_\_\_\_  
 Mother's/Guardian's Name: \_\_\_\_\_ Contact Number: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_ Zip Code: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Alternate Emergency Contact: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_  
 MEDICAL ALERTS (Allergic Reactions, Contact Lenses, etc.): \_\_\_\_\_

### Medical History:

**Parents** - This health record is a critical element in the determination of an athlete's risk of injury in sports. Please read and answer all the questions before seeing a physician for the athlete's physical examination.

	YES	NO	Don't Know
1) Has anyone in the athlete's family (grandparents, mother, father, brother, sister, aunt, uncle) died suddenly before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) Has the athlete ever stopped exercising because of dizziness or passed out during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) Does the athlete have asthma (wheezing), hay fever, or coughing spells after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4) Has the athlete ever had a broken bone, had to wear a cast, or had an injury to any joint?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5) Does the athlete have a history of concussion or head injury?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6) Has the athlete ever suffered a heat-related illness (heat exhaustion/heat stroke)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7) Does the athlete have a chronic illness or see a doctor regularly for any particular problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8) Does the athlete take any medication(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9) Is the athlete allergic to any medications or bee stings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10) Does the athlete have only one of any paired organs? (Eyes, ears, kidneys, testicles, ovaries)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12) Has the athlete had surgery or been hospitalized in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14) Are you, the athlete, worried about any problem or condition at this time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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## CTYFL Sports Physical Form

### PHYSICAL EXAMINATION FORM

Height: \_\_\_\_\_ **Vision:** Right \_\_\_\_\_ Left \_\_\_\_\_  
 Weight: \_\_\_\_\_ Uncorrected: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Pulse: \_\_\_\_\_ Corrected: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Blood Pressure: \_\_\_\_\_

	Normal	Abnormal Findings	Initials
1) Eyes			
2) Ears, Nose, Throat			
3) Mouth & Teeth			
4) Neck			
5) Cardiovascular			
6) Chest & Lungs			
7) Abdomen			
8) Skin			
9) Genitalia / Hernia (Male)			
10) Musculoskeletal			
a) Neck			
b) Spine			
c) Shoulders			
d) Arms/Hands			
e) Hips			
f) Thighs			
g) Knees			
h) Ankles			
i) Feet			
11) Neuromuscular			

Please Print / Stamp - *This Form must be signed by a licensed physician, physician's assistant or nurse practitioner.*

**Examiner's Name** \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_ 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.  
 (Doctor of Chiropractic Medicine is not satisfactory.)

Examiner's Signature \_\_\_\_\_ Date \_\_\_\_\_

Participation Restrictions: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_