Genoa Central Athletic Department
Athletic Physical Form

Name:_____ **School:**_____
Address:_____ **Age:** _____
_____ **Upcoming Grade:**_____
Phone:_____ **Date of Birth:**_____

Physical Examination

Height: _____ **Weight:**_____ **Vision: R/**_____ **L/**_____
BP:____/_____ **Pulse:**_____ **Both Eyes: 20/**___

Reference Ranges: **Corrected: YES NO**
10-12 YO>125/80 **Best Vision with both eyes must be 20/50 or better**
13-15 YO >135/85
16-18 YO>140/90

CHECK NORMAL, CIRCLE ABNORMAL, AND EXPLAIN BELOW:

EYES/NOSE	**( )**	**JOINTS**	
MOUTH	**( )**	**SHOULDERS**	**( )**
NECK	**( )**	**ELBOWS**	**( )**
HEART	**( )**	**WRIST**	**( )**
LUNGS	**( )**	**HIPS**	**( )**
ABDOMEN	**( )**	**KNEES**	**( )**
SKIN	**( )**	**ANKLES**	**( )**
EDEMA	**( )**	**SCOLIOSIS**	**( )**

EXPLAIN:

_____**PASS**
_____**PASS WITH RECOMMENDATIONS**
_____**PASS WITH RESTRICTIONS**
_____**UNABLE TO PARTICIPATE WITHOUT FURTHER EVALUATION BY A DOCTOR**

Physician Signature:_____**Date:**_____

NAME:_____ **Grade:**_____

Genoa Central Athletic Department
11986 SH 196
Texarkana, AR 71854
Office: (870)653-2088

Briefly explain any YES answers at the bottom:

QUESTION:		**CIRCLE**	
1.	Has anyone in the athlete's family (grandmother, grandfather, mother, father, brother, sister) died suddenly before the age of 50?	**YES**	**NO**
2.	Has the athlete ever passed out during exercise or stopped exercising because of extreme dizziness?	**YES**	**NO**
3.	Does the athlete have asthma?	**YES**	**NO**
4.	Has the athlete ever broken a bone, had to wear a cast or had an injury to any joint?	**YES**	**NO**
5.	Has the athlete ever suffered a concussion (got knocked out)?	**YES**	**NO**
6.	Has the athlete ever suffered a heat-exhaustion or heat stroke?	**YES**	**NO**
7.	Does the athlete have anything he/she wants to discuss with the physician?	**YES**	**NO**
8.	Does the athlete have any chronic illness or see a physician regularly for any particular problem?	**YES**	**NO**
9.	Does the athlete take any prescription medicine?	**YES**	**NO**
10.	Does the athlete have any allergies (medication, bee stings, food, etc.)? If yes, Please list:	**YES**	**NO**
11.	Does the athlete have only one of any paired organ (eyes, ears, kidneys, testicles, ovaries, etc.)?	**YES**	**NO**

I/We_____ give permission for _____
(Parent/guardian) (Student)
to participate in activities. My signature also allows the coaching staff to take my child to receive medical attention should the need occur and allows treatment as prescribed after medical examination.

STATEMENT BELOW MUST BE SIGNED WHEN TREATMENT REQUIRES SURGERY OR HOSPITAL CONFINMENT
I hereby authorize the hospital or doctors involved to give Preferred Care, Inc. all information regarding the insured's condition, including the history obtained, findings, and diagnosis. A photocopy of this form shall be considered as valid as the original.

DATE:_____ **Signature of the Parent/Guardian:**_____

I authorize payment directly to my medical providers for charges incurred for this claim. I understand that I am financially responsible for all charges not covered by this authorization.

Date:_____ **Signature of the Parent/Guardian:**_____