Sports Physical

Name: _____ DOB: _____ Date: _____

		YES	NO
1.	Do you feel dizzy, lightheaded, or faint when you run?	( )	( )
2.	Do you have a history of a heart problem?	( )	( )
3.	Has anyone in your family under 35 years old died of heart problems	( )	( )
4.	Do you have a history of seizures?	( )	( )
5.	Do you use inhalers?	( )	( )
6.	Have you ever had difficulty breathing or wheezing after exercise?	( )	( )
7.	Do you have any bone or joint problems?	( )	( )
8.	Have you had a recent illness?	( )	( )

HT: _____ WT: _____ BP: _____ P: _____

Allergies: _____ Medications: _____

SYSTEMS	NML	ABN	COMMENTS
APPEARANCE			
SKIN			
HEENT			
HEART			
LUNGS			
ABDOMEN			
MUSCULOSKELETAL			
NEUROLOGICAL			

( ) Cleared for participation ( ) Not Cleared for participation

Signature: _____

GENERAL CONSENT FOR ROUTINE TREATMENT OF MINORS

To be valid until patient attains 18 years of age or there is a change guardianship.

DATE:_____

NAME OF PATIENT:_____

BIRTHDATE:_____ SOCIAL SECURTIY #:_____

I consent to routine treatment for my child during clinic office visits. This routine treatment may include but is not limited to physical examinations for the ordinary diseases of childhood and such conditions as rashes, colds, hay fever, allergies, ear infections, broken bones, and for routine examinations my include x-rays, the drawing of blood, or obtaining of other specimens for testing. Routine vaccinations or medications may be given in the office.

I understand that I will be informed by the doctor of any unusual findings or medical follow-up needed.

I understand that a different specific consent form will be required for surgeries and other invasive procedures.

_____ _____

Signature of Parent/Legal Guardian Date

_____ _____

Signature of Witness Date