

Please Print

# CHANT SPORTS PHYSICAL



**Athlete's Full Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Sex:** M / F **Sport:** \_\_\_\_\_

**Contact Number:** \_\_\_\_\_ **Email Address:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_

<b>Questions:</b>	<b>Yes</b>	<b>No</b>
1. Has a doctor ever restricted/denied your participation in sports?		
2. Have you ever been hospitalized or spent a night in a hospital?		
3. Have you ever had surgery?		
4. Do you have any ongoing medical conditions (such as diabetes or asthma)?		
5. Are you presently taking any medications or pills (prescription or over the counter)?		
6. Do you have any allergies (medicine, pollen, food, bees, or other stinging insects)?		
7. Have you ever passed out during or after exercise?		
8. Have you ever felt dizzy during or after exercise?		
9. Have you ever had chest pain or chest discomfort during or after exercise?		
10. Do you tire more quickly than your peers during exercise?		
11. Have you ever had high blood pressure?		
12. Have you ever been told that you have a heart murmur, high cholesterol, or a heart infection?		
13. Have you ever had your heart race, or has your heart ever skipped a beat?		
14. Has anyone in your family died of heart problems or sudden death before the age of 50?		
15. Does anyone in your family have a heart condition?		
16. Has a doctor ever ordered a test on your heart (EKG, echocardiogram, etc.)?		
17. Have you ever had a head injury or concussion?		

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\_\_\_\_\_  
 Last Name                      First Name                      Middle Initial                      Date of Birth

Gender:    M    F                      Age:                                         Grade                   

**PHYSICAL EXAM** - To be completed by a physician or trained medical personnel under the supervision of a physician.

Height:                         Weight:                         Pulse:                         Blood Pressure:                   

Medical	Normal	Abnormal Findings	Initials
1. Eyes (vision)			
2. Ears, Nose, Throat			
3. Mouth & Teeth			
4. Neck/Lymph Nodes			
5. Cardiovascular			
6. Abdomen			
7. Chest & Lungs			
8. Skin			
9. Genitalia-Hernia (male)			
10. Heart (squatting to standing & supine)			
<b>Musculoskeletal: ROM, strength, etc.</b>			
• Neck			
• Spine/Back			
• Shoulders/Arm			
• Elbow/Forearm			
• Wrist/Hand			
• Hip/Thighs			
• Knees			
• Leg/Ankles			

This athlete is cleared to participate in sports       This athlete is not cleared for sports

Signature: \_\_\_\_\_

Date: \_\_\_\_\_