# CONWAY SCHOOLS PHYSICAL FORM

Name ___________________________________ Sex: **M** **F** Age: ____ Date of Birth: __________
**Please Print**
Parents Names: ____________________________**Grade entering** in **2018-2019**___ School _____________

Physicians Name: _______________________________________ Phone: _____________

| **Explain "YES" answers below:** | | **YES** | **NO** |
|---|---|---|---|
| 1. | Have you ever been hospitalized? | O | O |
| | Have you ever had surgery? | O | O |
| 2. | Are you presently taking any medication or pills? | O | O |
| 3. | Do you have any allergies (medicine, bees or other stinging insects?) | O | O |
| 4. | Have you ever passed out during or after exercise? | O | O |
| | Have you ever been dizzy during or after exercise? | O | O |
| | Have you ever had chest pain during or after exercise that required attention? | O | O |
| | Do you tire more quickly than your friends during exercise? | O | O |
| | Have you ever had High Blood pressure? | O | O |
| | Have you ever been told that you have a heart murmur? | O | O |
| | Have you ever had racing of your heart or skipped heartbeats? | O | O |
| | Has anyone in your family died of Heart Problems or a sudden death before age 50? | O | O |
| 5. | Do you have any skin problems (itching, rashes, acne)? | O | O |
| 6. | Have you ever had a head injury or concussion? | O | O |
| | Have you ever had a hit or blow to the head that caused confusion, prolonged headache and memory problems? | O | O |
| | Have you ever been knocked out or unconscious? | O | O |
| | Have you ever had a Seizure? | O | O |
| | Have you ever had a stinger, burner or pinched nerve? | O | O |
| 7. | Have you ever had heat or muscle cramps? | O | O |
| | Have you ever been dizzy or passed out in the heat? | O | O |
| | Do you get frequent muscle cramps when exercising? | O | O |
| 8. | Do you or someone in your family have sickle cell trait or disease? | O | O |
| 9. | Do you have trouble breathing or do you cough during or after activity? | O | O |
| | Have you ever used an inhaler or taken asthma medicine? | O | O |
| | Is there anyone in your family who has asthma? | O | O |
| 10 | Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guard, etc.)? | O | O |
| 11. | Have you had any problems with your eyes or vision? | O | O |
| | Do you wear glasses or contacts or protective eye wear? | O | O |
| 12. | Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints? | O | O |

[ ] Head [ ] Shoulder [ ] Thigh [ ] Neck [ ] Elbow [ ] Hand [ ] Back
[ ] Knee [ ] Foot [ ] Forearm [ ] Ankle [ ] Wrist [ ] Shin/calf [ ] Hip

| | | | |
|---|---|---|---|
| 13. | Have you had any other medical problems (infectious mononucleosis, diabetes, etc.) | O | O |
| 14. | Have you had a medical problem or injury since your last physical exam? | O | O |

15. When was your last **Tetanus Shot?** ____________
    When was your last **Measles Immunization?** ____________
16. **Females Only -** When was your first menstrual period? _________
    When was your last menstrual period? _________
    What was the longest time between your periods last year? ___________

**Explain "YES" answers here**: ______________________________________________________________

______________________________________________________________

**I HEREBY STATE THAT TO THE BEST OF MY KNOWLEDGE, MY ANSWERS TO THE ABOVE QUESTIONS ARE CORRECT.**

_______________________________ _______________________________ __________
**Signature of Parent/Guardian** **Signature of Athlete** **Date**

# CONWAY SCHOOLS PHYSICAL FORM

**NAME** ________________________________________ **Age:** _____ **Sex: M F** **Date of Birth:** ______________

**Ht.** _______________ **Wt.** ______________ **BP:** ________/_________ **Pulse:** __________

**Vision:** **R 20/** _____ **L 20/** _____ **Corrected Y N** **Pupils** ______

| | NORMAL | ABNORMAL FINDING | INITIALS |
|---|---|---|---|
| Cardiopulmonary | | | |
| Pulse | | | |
| Heart | | | |
| Lungs | | | |
| Abdominal | | | |
| Genitalia | | | |
| Musculoskeletal | | | |
| Neck | | | |
| Shoulder | | | |
| Elbow | | | |
| Wrist | | | |
| Hand | | | |
| Back | | | |
| Knee | | | |
| Ankle | | | |
| Foot | | | |
| Other | | | |

**CLEARED : YES NO**

**NOT CLEARED DUE TO:** ______________________________________________________________

Recommendation: ______________________________________________________________

**CLEARED [AFTER] COMPLETING EVALUATION/REHABILITATION FOR**: ______________
______________________________________________________________________________

______________________________________________________ **Date:** ________________
**Signature of Physician**