

THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

Athletic Competition Health Screening Form

NAME: _____ Family Physician: _____ Phone: _____

SCHOOL: _____ Address: _____

AGE: _____ PHONE: _____ GRADE: _____

DATE OF BIRTH: _____ Sex: _____

	VITALS	SATISFACTORY		PHYSICAL EXAMINATION COMMENTS	Recommend Follow-Up
		YES	NO		
Ht					
Wt					
BP					
GENERAL					
HEAD					
EYES				ACUTY R L	
ENT					
DENTAL					
CHEST					
HEART					
ABDOMEN					
GENTALIA					
SKIN					
EXTREMITIES BACK, NECK					
ALLERGY					

HEALTH HISTORY
Parent or Guardian
Answer "Yes" or "No" ONLY

	YES	NO
Chronic/Recurrent Illness?		
Hospitalization?		
Surgery Other Than Tonsils?		
Injuries Treated by Physician?		
Current Medications?		
Organs Missing?		
Heat Exhaustion/Stroke?		
Dizziness, Fainting, Convulsions and/or Headaches?		
Knocked Out?		
Concussion?		
Wear Glasses or Contacts?		
Hearing Defects?		
Dental Appliances: Bridge/Braces/Cap/Plate?		
Cough/Pain?		
Problems with Blood Pressure, Heart, or Murmurs?		
Problems with Liver, Spleen, or Kidney?		
Hernia?		
Recurrent Skin Disease?		
Bone/Joint Injury? Sprain/Dislocation? Injury that Caused a Missed Practice/Event?		
Allergy to Medications? Bee Stings? Name: _____		
Tetanus Booster in the Last 10 Years?		
Has anyone in the Athlete's family died suddenly before age 50?		
Asthma, Hayfever, or coughing spells after exercise?		

SUMMARY OF COMMENTS:

SPORTS PARTICIPATION APPROVED YES _____ NO _____

LIMITATIONS:

Physician Signature

Date

The Above Information is Current and Correct to the Best of My Knowledge

Signature of Parent or Guardian

Date

