



Folsom Jr. Bulldogs Youth Football/Cheer 2012

PART 1 (TO BE COMPLETED BY PLAYER/PARTICIPANT AND PARENT(S OR GUARDIAN))

| | | |
|-----------|------------|-------|
| LAST NAME | FIRST NAME | GRADE |
| BIRTHDATE | | |

HEALTH HISTORY (Must be completed prior to the examination)

| | Yes | No | Has this player/participant had any: | Yes | No | Does this player/participant: |
|-----|-----|----|--|-----|----|---|
| 1. | † | † | Chronic or recurrent illness? | 16. | † | Wear eyeglasses or contact lenses? |
| 2. | † | † | Illness lasting over 1 week? | 17. | † | Wear dental bridges, braces or plates? |
| 3. | † | † | Hospitalizations or Surgery? | 18. | † | Take any medications? (List below): |
| 4. | † | † | Nervous, psychiatric, or neurologic condition? | | | |
| 5. | † | † | Loss or nonfunctioning of organs (eye, kidney, liver, testicle) or glands? | | | |
| 6. | † | † | Allergies (medicines, insect bites, food)? | 19. | † | Injuries requiring medical care or treatment? |
| 7. | † | † | Problems with heart or blood pressure? | 20. | † | Neck or back pain or injury? |
| 8. | † | † | Chest pain or severe shortness of breath with exercise? | 21. | † | Knee pain or injury? |
| 9. | † | † | Dizziness or fainting with exercise? | 22. | † | Shoulder or elbow pain or injury? |
| 10. | † | † | Fainting, bad headaches or convulsions? | 23. | † | Ankle pain or injury? |
| 11. | † | † | Concussion or loss of consciousness? | 24. | † | Other joint pain or injury? |
| 12. | † | † | Heat exhaustion, heatstroke, or other problems with heat? | 25. | † | Broken bones (fractures)? |
| 13. | † | † | Racing heart, skipped, irregular heartbeats, or heart murmur? | 26. | † | Further history: |
| 14. | † | † | Seizures? | 27. | † | Birth defects (corrected or not)? |
| 15. | † | † | Severe or repeated instances of muscle cramps? | 28. | † | Death of parent or grandparent less than 40 years of age due to medical cause or condition? |
| | | | Date of last known tetanus (lockjaw) shot: _____ | 29. | † | Parent or grandparent requiring treatment for heart condition less than 50 years of age |
| | | | Date of last complete physical examination: _____ | | | Been seen by a physician on an emergency or urgent basis in the last 12-months? |

Explain all "YES" answers here along with any other fact or circumstance that should be disclosed to the examining physician (use reverse of form if needed):

PARENT/GUARDIAN'S AUTHORIZATION: I authorize a physician to perform a Sports Physical Evaluation on the player/participant. The information set forth above is complete and accurate and I know of no reason why the player/participant cannot fully and safely participate in the listed sports. I understand that this is solely a screening examination and that the absence of any health conditions or concerns listed below does not mean that player/participant is free from actual or potential harmful health conditions that may cause the player/participant injury or death while participating in sports. Any question or concern I may have regarding the player/participant's health or safety will be referred to our personal

| | |
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| physician for review and evaluation. PRINT NAME OF PARENT OR GUARDIAN | SIGNATURE OF PARENT OR GUARDIAN |
| ADDRESS | WORK PHONE |
| | HOME PHONE |
| | DATE |
| REGULAR PHYSICIAN'S NAME | OFFICE PHONE |

PART 11 (TO BE COMPLETED BY THE EXAMINING PHYSICIAN)

| | NORMAL | ABNORMAL (Describe) | |
|---------------------------------|--------|---------------------|--|
| Eyes/Ears/Nose/Throat | | | Height: |
| Skin | | | Weight: |
| Heart | | | Pulse: |
| Abdomen | | | BP: |
| Genital/hernia (males) | | | Recommendation: † Unlimited participation † Limited participation/specific sports, events or activities † Clearance withheld pending further testing/evaluation † No athletic participation |
| Musculoskeletal: | | | |
| a. Neck/Spine | | | |
| c. Shoulders/Back | | | |
| d. Arms/Hands/Fingers | | | |
| e. Hips/Thighs | | | |
| g. Knees/Legs | | | |
| h. Feet/Ankles | | | |
| Neurologic Screening Exam (NSE) | | | |

*One of the above **MUST** be checked.*

Comments:

| | | |
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| PRINT NAME OF PHYSICIAN (M.D./D.O. Only) | PHYSICIAN'S SIGNATURE | DATE |
|--|-----------------------|------|