THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

Athletic Competition Health Screening Form

NAME: _____
SCHOOL: _____
AGE: _____ GRADE: _____
DATE OF BIRTH: _____ SEX: _____

Family Physician: _____
Phone: _____
Address: _____

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, Kidney?		
Hernia?		
Recurrent Skin Disease?		
Bone/ Joint Injury? Sprain / Dislocation? Injury that Caused a Missed Practice / Event?		
Allergy to Medications? Name:		
Tetanus Booster in the Last 10 years?		

Vitals	YES	NO	PHYSICAL EVALUATION / COMMENTS	RECOM-MEND FOL-LOWUP
HT:				
WT:				
BP:				
General:				
HEAD:				
EYES:			Acuity: RT: LT:	
ENT:				
DENTAL:				
CHEST:				
HEART:				
ABDOMEN:				
GENITALIA:				
SKIN:				
EXTREMITIES (BACK, NECK)				
ALLERGY:				

SUMMARY OF COMMENTS:

The above information is Current and Correct to the Best of my Knowledge.

_____
Signature of Parent / guardian

_____
DATE

SPORTS PARTICIPATION APPROVED:
Yes _____ No _____

LIMITATIONS: _____

_____
PHYSICIAN'S SIGNATURE

DATE: _____