Tioga Central Athletic Health History

Name: ________________________
Date: ________________________
Sex: ___ Age ____ Grade ___
Sports:_______________________
Student Address:
____
Phone: _______________________

Date of Birth: _____________________
Emergency Contact:
Name: ______________________________
Phone Number: ______________________
2nd Emergency Contact:
Name: ______________________________
Phone Number: ______________________

	Yes	No	Explain "Yes" Answers Below:
Have you ever been hospitalized?	☐	☐	____________________
Have you ever had surgery?	☐	☐	____________________
Are presently taking any medications or pills?	☐	☐	____________________
Do you have allergies (medicine/bees/other insects)?	☐	☐	____________________
Have you ever passed out during or after exercise?	☐	☐	____________________
Have you ever been dizzy during or after exercise?	☐	☐	____________________
Have you ever had chest pain during or after exercise?	☐	☐	____________________
Do you tire more quickly than friends during exercise?	☐	☐	____________________
Have you ever had high blood pressure?	☐	☐	____________________
Have you ever been told that you have a heart murmur?	☐	☐	____________________
Have you ever had racing of your heart or skipped beats?	☐	☐	____________________
Has anyone in your family died of heart problems or a sudden death before age 50?	☐	☐	____________________
Do you have any skin problems (itching, rashes, acne)?	☐	☐	____________________
Have you ever had a head injury?	☐	☐	____________________
Have you ever been knocked out or unconscious?	☐	☐	____________________
Have you ever had a seizure?	☐	☐	____________________
Have you ever had a stinger, burner, or pinched nerve?	☐	☐	____________________
Have you ever had heat or muscle cramps?	☐	☐	____________________
Have you ever been dizzy passed out in the heat?	☐	☐	____________________
Do you have trouble breathing or do you cough during or after activity?	☐	☐	____________________
Do you use any special equipment (pads, braces, neck rolls Mouth guard, eye guard, etc)?	☐	☐	____________________
Have you had any problems with your eyes or vision?	☐	☐	____________________
Do you wear glasses or contacts or protective eyewear?	☐	☐	____________________
Have you every sprained/strained, dislocated, fractured, Broken, or had repeated swelling or other injuries of Any bones or joints?	☐	☐	____________________

☐ head ☐ shoulder ☐ thigh ☐ neck ☐ elbow
☐ Knee ☐ chest ☐ forearm ☐ foot ☐ back
☐ Wrist ☐ ankle ☐ hip ☐ shin/calf

	Yes	No	
Have you had any other medical problems (infectious mononucleosis, Diabetes, etc.)?	☐	☐	____________________
Have you had a medical problem or injury since your last Evaluation?	☐	☐	____________________
Are you missing function of eye or kidney?	☐	☐	____________________

I hereby state that, to the best of my knowledge, my answers to the above questions are correct. I also agree to emergency medical treatment as deemed necessary by designated school authorities.

Parent/Guardian Print Name: ______________________________ Date: ____________________

Parent/Guardian Signature: ______________________________ Insurance Carrier ______________

Policy # ________________

Tioga Central Sports Physical Form

Name_____________________________ Sport ___________________________

Height________ Weight________

Pulse/Resp:_____/_____ BP:_____/_____

Vision: R _____/_____ L _____/_____ Corrected: Y N

MEDICAL: Skin: Scoliosis:

Heent: ABD:

Heart/Lungs: Genital:

Neuro: Tanner:

FLEXIBILITY:

Cervical: Hip Flexors:

UE: Hamstrings:

LB: Achilles:

Other:

Recommendations: No Significant Findings _____

ORTHOPEDIC:

UE: LE:

Recommendations: No Significant Findings _____

GAIT:

Recommendations: No Significant Findings _____

EDUCATION:

Strengthen: Stretch: Other:

CLEARANCE:

a. Cleared: ____________

b. Cleared only after completion of rehabilitation /evaluation for: _______________________________

c. Not Cleared for: ___collision ___contact ___noncontact

REASON: ____

Physician Signature: _______________________________ Date: _______