# CTYFL Sports Physical Form

Name: _____ Gender: M F Date of Birth: ___/___/___

Father's / Guardian's Name: _____ Contact Number: _____

Mother's / Guardian's Name: _____ Contact Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Home Phone: _____

Alternate Emergency Contact: _____ Daytime Phone: _____

**MEDICAL ALERTS** (Allergic Reactions, Contact Lenses, etc.): _____

**Medical History:**

**Parents:** ***This health record is a critical element in the determination of an athlete's risk of injury in sports. Please read and answer all the questions before seeing a physician for the athlete's physical examination.***

| | | YES | NO | Don't Know |
|---|---|---|---|---|
| 1) | Has anyone in the athlete's family (grandparents, mother, father, brother, sister, aunt, uncle) died suddenly before age 50? | ☐ | ☐ | ☐ |
| 2) | Has the athlete ever stopped exercising because of dizziness or passed out during exercise? | ☐ | ☐ | ☐ |
| 3) | Does the athlete have asthma (wheezing), hay fever, or coughing spells after exercise? | ☐ | ☐ | ☐ |
| 4) | Has the athlete ever had a broken bone, had to wear a cast, or had an injury to any joint? | ☐ | ☐ | ☐ |
| 5) | Does the athlete have a history of concussion or head injury? | ☐ | ☐ | ☐ |
| 6) | Has the athlete ever suffered a heat-related illness (heat exhaustion / heat stroke)? | ☐ | ☐ | ☐ |
| 7) | Does the athlete have a chronic illness or see a doctor regularly for any particular problem? | ☐ | ☐ | ☐ |
| 8) | Does the athlete take any medication(s)? | ☐ | ☐ | ☐ |
| 9) | Is the athlete allergic to any medications or bee stings? | ☐ | ☐ | ☐ |
| 10) | Does the athlete have only one of any paired organs? (eyes, ears, kidneys, testicles, ovaries) | ☐ | ☐ | ☐ |
| 11) | Has the athlete had an injury in the last year that caused the athlete to miss 3 or more consecutive days of practice or competition? | ☐ | ☐ | ☐ |
| 12) | Has the athlete had surgery or been hospitalized in the past year? | ☐ | ☐ | ☐ |
| 13) | Has the athlete missed more than 5 consecutive days of participation in usual activities because of illness, or has the athlete had a medical illness diagnosed that has not been resolved in the past year? | ☐ | ☐ | ☐ |
| 14) | Are you, the athlete, worried about any problem or condition at this time? | ☐ | ☐ | ☐ |

**Please give details on any "YES" answer from the above health history:**

_____

_____

_____

_____

_____

## CTYFL Sports Physical Form

## PHYSICAL EXAMINATION FORM

Height: _____ **Vision:** **Right** **Left**

Weight: _____ Uncorrected: _____/_____ _____/_____

Pulse: _____ Corrected: _____/_____ _____/_____

Blood Pressure: _____

| | Normal | Abnormal Findings | Initials |
|---|---|---|---|
| 1) Eyes | | | |
| 2) Ears, Nose, Throat | | | |
| 3) Mouth and Teeth | | | |
| 4) Neck | | | |
| 5) Cardiovascular | | | |
| 6) Chest and Lungs | | | |
| 7) Abdomen | | | |
| 8) Skin | | | |
| 9) Genitalia / Hernia (Male) | | | |
| 10) Musculoskeletal | | | |
| a) Neck | | | |
| b) Spine | | | |
| c) Shoulders | | | |
| d) Arms / Hands | | | |
| e) Hips | | | |
| f) Thighs | | | |
| g) Knees | | | |
| h) Ankles | | | |
| i) Feet | | | |
| 11) Neuromuscular | | | |

Please Print / Stamp – ***This Form must be signed by a licensed physician, physician's assistant or nurse practitioner.***

**Examiner's Name:** _____

Street Address: _____

City, State, Zip _____ Telephone: _____

I certify that I have examined this athlete and found him/her medically qualified to participate in sports. I also certify that I am a licensed medial physician, physician's assistant, or family nurse practitioner.

**Examiner's Signature:** _____ Date: _____

Participation Restrictions: _____

_____