SKAGIT PEDIATRICS, LLP SPORTS PHYSICAL EVALUATION

*******This side to be filled out by parent or guardian******

Name:_____ Age:_____

School:_____ Grade:_____

CIRCLE THE SPORTS YOU PLAY: Baseball Basketball Cheerleading Cross-country Football Soccer Softball Swimming Track Volleyball Wrestling Other:_____

Please answer truthfully all of the following questions. It is important to include all pertinent information.
A parent or guardian must review the questions and sign below before your sports physical can be done.

List all the medications you are currently taking and what the medication is for:

_____

_____

	Yes	No	Explain & give dates
1. Has anyone in your family died of heart problems or sudden unexplained death before age 50?	( )	( )	
2. Does anyone in your family have a heart arrhythmia, Long QT syndrome, Marfan syndrome, or hypertrophic cardiomyopathy	( )	( )	
3. Have you ever passed out or felt dizzy during or after exercise?	( )	( )	
4. Have you ever had chest pain or felt your heart beat oddly during exercise?	( )	( )	
5. Do you cough, wheeze or have trouble breathing during or after exercise?	( )	( )	
6. Do you have asthma or breathing problems?	( )	( )	
7. Have you ever broken a bone, worn a cast or injured a joint (such a knee or ankle)?	( )	( )	
8. Have you ever been knocked out or had a concussion?	( )	( )	
9. Do you have a chronic illness or see a medical provider regularly?	( )	( )	
11. Do you have only one of any normally paired organs (such as eyes, kidneys, etc.)?	( )	( )	

For women only

12. How old were you when you had your first period? _____
13. In the past year what is the longest time you have gone between periods? _____

I have reviewed the above questions and answers with my son or daughter. I understand that a sports physical is not a complete health evaluation. I understand that the purpose of a sports physical is to identify only those medical conditions which might worsen, or cause increased risk of injury or death, with participation in sports activities.

Signature of Parent or Guardian:_____Date:_____

SKAGIT PEDIATRICS, LLP PHYSICAL EVALUATION

PHYSICAL EXAMINATION TO BE FILLED OUT BY PROVIDER

Name: _____ DOB_____ Drug Allergy:_____

Height: _____ Weight: _____ Vision: (R) 20/_____
(L) 20/_____
Age: _____ Pulse: _____ (B) 20/_____
Corrected: No / Yes
BP (left arm, standing): _____/ _____ glasses contacts
Vision Reference Range: vision with both eyes better than 20/50.

Pupils: equal unequal with _____ > _____

	Normal	Abnormal	Explain
Cardiopulmonary Examination:			
Lungs	( )	( )	
Pulse	( )	( )	
Heart	( )	( )	
Musculoskeletal Screening:			
Neck	( )	( )	
Shoulder	( )	( )	
Elbow	( )	( )	
Wrist/Hand	( )	( )	
Back	( )	( )	
Knee	( )	( )	
Ankle	( )	( )	
Foot	( )	( )	
Abdomen:	( )	( )	
Skin:	( )	( )	

Other: (Physical examination pertinent to history)

Recommendation:

_____ 1. Cleared for all sports without restriction
_____ 2. Cleared, with restrictions: _____
_____ 3. Not cleared for any sport Reason: _____
_____ 4. Deferred- Reason: _____
_____

If Deferred - ***Must have Addendum completed to be valid***

Provider Signature: _____ Date of exam _____

Provider (printed name) _____

Addendum:
_____Cleared based on_____
_____

Provider Signature: _____ Date of addendum _____

Provider (printed name) _____

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