CONSENT FORM & HISTORY SHEET **School: DAVENPORT**

Sports Physical for Student Athlete

A. Name_____Grade this Year_____Birth Date_____Age_____

B. Parent's Names: Father_____Mother_____Father's Ht:_____Mother's Ht:_____

C. Home Phone:_____ Parent/Guardian Currently Living with_____

D. Mailing Address:_____
PO Box/Other City Zip Code

E. Daytime Phone Both Parents/Guardians: #1_____#2_____

F. What sports do you plan to participate in this coming year?
1._____2._____3._____4._____5._____

G. List all medications used on a regular basis (include vitamins, allergy medications, minor pain medications, etc.)
1._____2._____3._____4._____5._____

H. List all previous surgeries:
1._____2._____3._____4._____5._____

I. List the illness that caused all previous hospitalizations—other than the surgeries listed above:
1._____2._____3._____4._____5._____

J. Have you had a condition that required medical attention to a: MUSCLE ( )YES ( )NO; JOINT ( )YES ( )NO; TENDON ( )YES ( )NO; BONE ( )YES ( )NO: EXPLAIN_____

K. List all medication allergies:
1._____2._____3._____4._____5._____
Do you get a rash from tape? ( )YES ( )NO Do you get a rash from liniment? ( )YES ( )NO

L. Has a blood relative ever suffered a heart attack, stroke, or sudden death during sports, or at a young age (less than 45 years)? ( )YES ( )NO
If yes list: Relation_____Age_____Illness_____

M. **Have you ever had or been diagnosed with:**	YES	NO
1. Seizure or epilepsy	( )	( )
2. Asthma	( )	( )
3. Collapsed lung	( )	( )
4. Frequent or severe headaches	( )	( )
5. Concussion or loss of consciousness (other than simple fainting)	( )	( )
6. Heart murmur	( )	( )
7. Rheumatic heart disease	( )	( )
8. High blood pressure	( )	( )
9. Bleeding disorder	( )	( )
10. Anemia not corrected with iron therapy	( )	( )
11. Loss of/or impaired vision in one or both eyes (other than simple eye glasses)	( )	( )
12. Loss of/or impaired function in one or both kidneys	( )	( )
13. Loss of/or injury to one or both testicles	( )	( )
14. Hepatitis or enlarged liver	( )	( )
15. An injury to arms or legs that required casting, surgery or crutches for more than a few days	( )	( )
16. Head or neck injury that caused numbness or burning pain in the arms or hands	( )	( )
17. Do you wear eye glasses or contact lenses? ( )YES ( )NO During practice or competition?	( )	( )
18. Scoliosis or other back problems	( )	( )
19. Arm or leg deformity	( )	( )
20. Became weak or ill when exposed to high temperature	( )	( )

STUDENT ATHLETE SIGNATURE_____**DATE**_____

I hereby give permission to _____to perform a sports physical on the above mentioned student.

PARENT/GUARDIAN SIGNATURE_____**DATE**_____

PHYSICAL EXAMINATION

Age:_____ Pulse:_____

Height:_____ Blood Pressure:_____

Weight:_____ Visual Acuity: Left 20/____ Right 20/____

Optional

Urinalysis:
Body Fat %
HCT:
EST VO2 Max:
Audiometry:

Normal			**Abnormal**	
( )	1.	Head	( )	_____
( )	2.	Eyes (pupils), ENT	( )	_____
( )	3.	Teeth	( )	_____
( )	4.	Chest	( )	_____
( )	5.	Lungs	( )	_____
( )	6.	Heart	( )	_____
( )	7.	Abdomen	( )	_____
( )	8.	Genitalia	( )	_____
( )	9.	Neurologic	( )	_____
( )	10.	Skin	( )	_____
( )	11.	Physical Maturity	( )	_____
( )	12.	Spine, Back	( )	_____
( )	13.	Shoulders, Upper Extremities	( )	_____
( )	14.	Lower Extremities	( )	_____

Assessment: ( ) Full Participation

( ) Limited Participation (describe limitations, restrictions):

_____

_____

( ) Participation Contraindicated (list reasons):

_____

_____

Recommendations (equipment, taping, rehabilitation, etc.):

_____

_____

DATE:_____ Examiner's Signature:_____

Examiner's Phone: ( )_____ PRINT EXAMINER'S NAME:_____