Southern Sports Academy
Sports Physical Form

*This form must be completed and returned BEFORE the first day of any sports participation. NO participation will be allowed until it is completed and signed by a physician, physician's asst, or nurse practitioner.

*****If you have a previous physical form that was filled out after January 1st, 2017, you may present us with that form. If not you must receive a physical within the same year as you are participating at SSA. It must be similar to this form, documenting that you are **medically qualified to play sports**. We must have an original document (no copies). If you don't have an original, then your doctor can fill out this form for you. If it's been less than a year, your doctor should not require another exam to complete this. It must be signed by a licensed physician, physician's assistant, or nurse practitioner.

Name: _____Gender: M F Date of Birth: ____/____/____

Father's name: _____Phone: _____

Mother's name: _____Phone: _____

Street address: _____

City: _____ State: _____ Zip Code: _____ Telephone:_____

Insurance Carrier:_____ Telephone:_____

Alternate Emergency Contact Person: _____

Phone: _____

Please indicate MEDICAL ALERTS such as allergic reactions, etc.: _____

_____

Medical History:

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

1.	Has anyone in the athlete's family (grandparents, mother, father, brother, sister, aunt, uncle) died suddenly before age 50?	**YES NO Don't know**
2.	Has the athlete ever stopped exercising because of dizziness or passed out during exercise?	**YES NO Don't know**
3.	Does the athlete have asthma (wheezing), hay fever, or coughing spells after exercise?	**YES NO Don't know**
4.	Has the athlete ever had a broken bone, had to wear a cast, or had an injury to a joint?	**YES NO Don't know**
5.	Does the athlete have a history of concussion (getting knocked out)?	**YES NO Don't know**
6.	Has the athlete ever suffered a heat-related illness (heat stroke)?	**YES NO Don't know**
7.	Does the athlete have a chronic illness or see a doctor regularly for any particular problem?	**YES NO Don't know**
8.	Does the athlete take any medication(s)?	**YES NO Don't know**
9.	Is the athlete allergic to any medication(s) or bee stings?	**YES NO Don't know**
10.	Does the athlete have only one of any paired organs? (eyes, kidneys, testicles, lungs)	**YES NO Don't know**
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?	**YES NO Don't know**
12.	Has the athlete had surgery of been hospitalized in the past year?	**YES NO Don't know**
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?	**YES NO Don't know**
14.	Are you, the athlete, worried about any problem or condition at this time?	**YES NO Don't know**

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

_____

_____

_____

_____

PHYSICAL EXAM - TO BE COMPLETED BY PHYSICIAN

Height: _____ Weight: _____ Pulse: _____ BP: _____

Vision: R ____/____ uncorrected R _____/_____ corrected L ____/____ uncorrected L ____/____ corrected

	Normal	Abnormal Findings	Initials
1. Eyes			
2. ENT			
3. Mouth & Teeth			
4. Neck			
5. Cardiovascular			
6. Chest & Lungs			
7. Abdomen			
8. Skin			
9. Genitalia - Hernia (male)			
10. Musculoskeletal: ROM, strength, etc			
a. neck			
b. spine			
c. shoulders			
d. arms/hand			
e. hips			
f. thighs			
g. knees			
h. ankles			
i. feet			
11. Neuromuscular			

Please Print/Stamp

Physician's Name: _____

Street Address: _____

City, State, Zip Code: _____

Telephone: _____

I certify that I have examined this athlete and found him medically qualified to participate in sports. I also certify that I am a licensed physician, physician's assistant, or family nurse practitioner. (Doctor of Chiropractic Medicine is not satisfactory)

Physician Signature _____ Date_____

Participation Restrictions: _____

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Additional Notes: _____

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