GLENN MEDICAL CENTER
FAMILY CARE CENTER
1133 W. Sycamore Street
Willows, CA 95988
(530) 934-1816

SPORTS PHYSICAL

Name_____		Date:_____	
Address: _____		City, State, Zip _____	
Phone#_____	DOB: _____	Age: _____	

PATIENT HISTORY — ***TO BE FILLED OUT BY PARENT/GUARDIAN***

☐YES ☐NO Does your child have any of the following conditions:
- ☐ Heart Problems
- ☐ Cardiac
- ☐ Asthma

☐YES ☐NO Does your child need to stop often when running twice around a one-quarter mile track?
☐YES ☐NO Any history of neck injury or iinstability?
☐YES ☐NO Is your child under a doctor's care for any chronic illnesses? If Yes, please specify:_____
_____

List all Allergies to medications/Allergic reactions (ex: hay fever) _____
_____

List ALL Medications your child is currently taking, including inhalers, allergy medications and over the counter medications. _____
_____

PARENT SIGNATURE: _____

VITAL SIGNS

HT.	WT.	TEMP	P	R	B/P	BMI

VISUAL ACCUITY 20/20	Corrected Vision	Notes:
B 20/ R 20/ L 20/	B 20/ R 20/ L 20/	

PHYSICAL EXAM:

☐N ☐AB Appearance _____
☐N ☐AB Eyes _____
☐N ☐AB Ears _____
☐N ☐AB Nose/Mouth _____
☐N ☐AB Heart _____
☐N ☐AB Chest/Lungs _____
☐N ☐AB Abdomen _____
☐N ☐AB Extremities _____
☐N ☐AB Skeletal/Muscle _____
☐N ☐AB Neurological _____
☐N ☐AB Back _____
☐N ☐AB Hernia (males) _____

☐ Student must wear corrective lenses.
Condition(s) to be watched: _____
_____
_____

I hereby certify that the above named student is physically fit to engage in sports.

Physician Signature: _____ Date: _____

Please turn over and complete the back

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Sports Physical Questionnaire

One purpose of health screening before sports participation is to identify students at risk of serious health problems because of unexpected heart conditions. Every year many young persons die due to heart disease which was unsuspected- sports participation increases the risk of such death. In order to better identify which students may be at risk, please answer carefully the following questions, and please be prepared to provide details to the examining physician.

1. Has your child ever passed out/knocked out or nearly passed out during or after exercise? ☐Yes ☐No
2. Has your child ever had discomfort, pain, pressure or tightness in their chest during exercise? ☐Yes ☐No
3. Does your child get lightheaded or feel more short of breath than expected during exercise? ☐Yes ☐No
4. Has a doctor ever diagnosed in your child any heart problem, high blood pressure, high cholesterol, heart murmur, Kawasaki's disease, or unexplained seizure disorder? ☐Yes ☐No
5. Has anyone family member or relative died of heart problems or had an unexplained sudden death before the age of 50 (including drowning, car accident, or sudden infant death syndrome)? ☐Yes ☐No
6. Has anyone in your family had unexplained fainting, seizures, or near drowning? ☐Yes ☐No
7. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator? ☐Yes ☐No
8. Does anyone in your famly have hypertrophic cardiomyopathy, Marfan syndrome, arrythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, cathecholaminergic polymorphic ventricular tachycardia? ☐Yes ☐No
9. Does your child take a stimulant medication (Ritalin, Concerta, Vyvanse, Focalin)? ☐Yes ☐No

If any questions have been answered "yes", please read and answer the following:

A yes answer to any of the above questions may require your physician to order tests including an electrocardiogram (EKG) in order to determine whether your child can safely play sports. These additional tests may incur additional fees to the child's parent or care giver and/or their insurance company.

10. Have you discussed the medical risks of sports participation with your provider? ☐Yes ☐No
11. Has your child had an EKG? ☐Yes ☐No
12. If so, was the test entirely normal? ☐Yes ☐No