GLENN MEDICAL CENTER

FAMILY CARE CLINIC

1133 W. Sycamore Street
Willows, Ca 95988
(530) 934-1832

SPORTS PHYSICAL

Name: _____ Date: _____

M.R. #: _____ DOB: _____ AGE: _____ Phone #: _____

PATIENT HISTORY: ***TO BE FILLED OUT BY PARENT/GUARDIAN*** (Please circle appropriate answer.)

YES NO Does your child have any chronic disease(s)/conditions? If yes, please specify:
_____

YES NO Any relatives with heart attack/conditions under age 50?

YES NO Does your child need to stop often when running twice around a one-quarter mile track?

YES NO Does your child currently take any medications? If yes, please specify:
_____

YES NO Has your child ever passes out or been knocked out while exercising?

YES NO Has your child had an illness or injury:

A. Requiring Emergency Room visit/hospitalization?
B. Requiring surgery?
C. Causing him/her to miss a game?
D. Caused by allergies (i.e. hay fever, hives, or asthma)?

YES NO Is your child under a doctor's care? If yes, please specify: _____
_____

YES NO Does your child have any problems we should be made aware of? If yes, please specify:
_____
_____

PARENT SIGNATURE: _____

VITAL SIGNS:

B/P _____ P _____ R _____ Temp. _____ Wt. _____ Ht. _____ LMP _____

Allergies: _____
_____

COMMENT: _____
_____
_____
_____

PHYSICAL EXAM:

N	AB					
( )	( )	Appearance _____	( )	( )	Abdomen _____
( )	( )	Eyes _____	( )	( )	Extremities _____
( )	( )	Ears _____	( )	( )	Skeletal/Muscle_____
( )	( )	Nose/Mouth_____	( )	( )	Neurological_____
( )	( )	Heart _____	( )	( )	Back _____
( )	( )	Chest/Lungs_____	( )	( )	Hernia (males) _____

Condition(s) to be watched/or lenses needed: _____
_____

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

_____ Provider Signature