

Westgate Christian University
PHYSICAL FORM
(PLEASE FILL OUT BOTH SIDES OF FORM)

PHYSICAL EXAM – TO BE COMPLETED BY PHYSICIAN

Name: _____ Gender: M F Date of Birth: ____/____/____
Father's Name: _____ Phone#: _____
Mother's Name: _____ Phone#: _____
Street address: _____
City: _____ State: _____ Zip Code: _____ Phone: _____
Alternate Emergency Contact Person: _____ Phone: _____

Please indicate MEDICAL ALERTS such as allergic reactions, contact lenses, 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 any 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 medications or bee stings? YES NO Don't Know
 10. Does the athlete have only one of any paired organs? (Eyes, ears, kidneys, testicles, ovaries) 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 or 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.

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ATHLETES NAME: _____

Height _____ Weight _____ Pulse _____ Blood Pressure _____
Vision: R _____ / _____ uncorrected R _____ / _____ corrected L _____ / _____ uncorrected L _____ / _____ corrected

Normal Abnormal Findings Initials

1. Eyes
2. Ears, Nose, Throat
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/ hands
 - 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/her medically qualified to participate in sports. I also certify that I am a licensed medical physician, physician's assistant, or family nurse practitioner. (Doctor of Chiropractic Medicine is not satisfactory.)

Physician Signature _____ Date _____

PARTICIPATION RESTRICTIONS:
