

THE AMERICAN ACADEMY OF FAMILY PHYSICIANS
Athletic Competition Health Screening Form

NAME: _____

SCHOOL: _____

AGE: _____ Grade: _____

DATE OF BIRTH: _____ SEX: _____

Family Physician: _____ Phone: _____

Address: _____

HEALTH HISTORY
Parent or guardian
Answer "yes" or "no" ONLY YES NO

Chronic/Recurrent Illness? YES NO

Hospitalization? YES NO

Surgery Other Than Tonsils? YES NO

Injuries Treated by Physician? YES NO

Current Medication? YES NO

Organs Missing? YES NO

Heat Exhaustion/Stroke? YES NO

Dizziness, Fainting,
Convulsions and/or
Headaches? YES NO

Knocked Out? YES NO

Concussion? YES NO

Wear Glasses or Contacts? YES NO

Hearing Defects? YES NO

Dental Appliances
Bridge/Brace/Cap/Plate? YES NO

Cough/Pain? YES NO

Problems with Blood
Pressure, Heart, or
Murmurs? YES NO

Problem with Liver,
Spleen, Kidney? YES NO

Hernia? YES NO

Recurrent Skin Disease? YES NO

Bone/Joint Injury? YES NO

Sprain/Dislocation?
Injury that Caused a Missed
Practice/Event? YES NO

Allergy to Medications?
Name: _____ YES NO

Tetanus Booster in the
Last 10 Years? YES NO

The Above Information is Current and
Correct to the Best of My Knowledge

VITALS	SATISFACTORY		PHYSICAL EVALUATION COMMENTS	Recommend Follow-Up
	YES	NO		
Ht				
Wt				
BP				
GENERAL				
HEAD				
EYES			ACUITY R L	
ENT				
DENTAL				
CHEST				
HEART				
ABDOMEN				
GENITALIA				
SKIN				
EXTREMITIES BACK, NECK				
ALLERGY				

SUMMARY OF COMMENTS:

SPORTS PARTICIPATION APPROVED YES _____ NO _____

LIMITATIONS:

Signature of
Parent or Guardian

Date

Physician Signature

Date