7450 MEMORIAL WOODS DRIVE
HOUSTON, TEXAS 77024
713.290.2500
FAX: 713.2902508

2020-2021 ATHLETE PHYSICAL FORM

Student's Name _____ Preferred Name (Nickname) _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Parent's e-mail address _____

Grade in 2020-2021 _____ What sport(s) are you playing (1) _____ (2) _____ (3) _____ (4) _____

Personal Physician _____ Physician's Phone No. _____

Name of Emergency Contact _____ Relationship _____ Phone No. _____

Physical Examination: Pre-participation Physical Evaluation: Must be completed before a student participates in any practice, before, during or after school (both in-season and out-of-season) or in games/meets/competitions.

Height _____ Weight _____ Pulse _____ BP _____/_____

Vision: R 20 / _____ L 20 / _____ Corrected: ❑ Yes ❑ No Contact Lenses _____ Glasses _____ Pupils: Equal _____ Unequal _____

	NORMAL	ABNORMAL FINDINGS
MEDICAL		
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart-Auscultation of the heart supine		
Heart-Auscultation of the heart standing		
Heart-Lower extremity pulses		
Pulses		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		
Neuro-muscular		
Spinal Screening ❑ Pass ❑ Fail		

Comments regarding Abnormal Findings: _____

CIRCLE POSITIVE POINTS AND EXPLAIN PREVIOUS HISTORY OF:

Allergies	Emotional Disturbance	Bone or Joint Disease/Injury
Allergy to medications	Asthma/exercise induced asthma	Diabetes
Tetanus Immunization	Head Injury/Unconsciousness	Epilepsy/Fainting spells
Heart Disease		

Explanation _____

Previous surgeries: _____

Is the student taking any medication? ❑ Yes ❑ No If Yes, please explain _____

_____

PARTICIPATION RECOMMENDATIONS – CLEARED: ❑ **Yes** ❑ **No**

Cleared after completing evaluation and/or rehabilitation for: _____

List any activity this student should be excluded from: _____

Not cleared for: _____ **Reason:** _____

Recommendations: _____

I certify that on this date this student is up to date on all immunizations required by the State of Texas ❑ **Yes** ❑ **No**

Note to the Physician: **DO NOT SIGN if student fails.**

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, or a Licensed Nurse Practitioner. Chiropractic examinations will not be accepted.

Name of Physician (print/type): _____ Date of Exam: _____

Physician's Phone Number(s): _____

Physician's Address: _____

Physician's Signature: _____

First Baptist ACADEMY