ATHLETIC PHYSICAL FORM
This page to be completed by parent or guardian.

DATE OF EXAM ________________________________________

Name _____________________________ Sex _______ Age _______ Date of birth _____________

Grade ______ School ___________________________ Sport(s) ___________________________

Address ____________________________ Phone _____________________________

Personal physician _______________________________________________________________

In case of emergency, contact ____________________________ Relationship ________

Name ____________________________ Phone (H) ____________________ (W) ____________

Name ____________________________ School __________________________ Sport(s) __________

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete ____________________________ Date _____________

Signature of parent/guardian ____________________________ Date _____________

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Follow-Up Questions on More Sensitive Issues

1. Do you feel stressed out or under a lot of pressure?  
2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?  
3. Do you feel safe?  
4. Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke?  
5. During the past 30 days, did you use chewing tobacco, snuff, or dip?  
6. During the past 30 days, have you had at least 1 drink of alcohol?  
7. Have you ever taken steroid pills or shots without a doctor’s prescription?  
8. Have you ever taken any supplements to help you gain or lose weight or improve your performance?  
9. Questions from the Youth Risk Behavior Survey (http://www.cdc.gov/HealthyYouth/yrbs/index.htm) on guns, seatbelts, unprotected sex, domestic violence, drugs, etc
EMERGENCY INFORMATION

Allergies

Other Information

IMMUNIZATIONS (eg, tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; poliomyelitis; pneumococcal; meningococcal; varicella)

- Up to date (see attached documentation)
- Not up to date

Name of physician (print/type) ____________________________ Date ______________

Address _______________________________________________________________________________

Phone ____________________________

Signature of physician ____________________________, MD or DO