

Hill Air Force Base Youth Programs Sports Participation Physical Examination Form

YOUTH CENTER PHONE: 777-2419 / 777-3591

FAX: (801) 777-3596

Patient Name (First, MI, Last)	Date Of Birth	Sponsor Social Security Number (last four numbers)
<u>Sponsor Name</u>	<u>Sponsor Grade</u>	<u>Participants Relationship To Sponsor</u>

Patient Information:

<u>GRADE</u>	<u>AGE</u>	<u>WEIGHT</u> (kgs/lbs)	<u>HEIGHT (cm/in)</u>	<u>BLOOD PRESS.</u>	LT	VISION	RT
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Primary Sport Exam For: ALL SPORTS Football Basketball Baseball Soccer OTHER: _____

Immunizations: UTD UTD Reported By: _____ NEEDS: _____

Medical History: (Circle or Check) **IF FILLING OUT DIRECTLY ON "EXCEL" JUST "TAB" & TYPE OVER THE BOX**

YES	NO		NORMAL	AB - NORMA	
		Sudden death/heart disease in family before age "50"?			ENT
		Ever had a broken bone or had to wear a cast or had an injury to the joints?			MOUTH / TEETH
		History of getting knocked out, concussion, or seizure?			NECK
		Is there anything you see a doctor regularly about?			CARDIOVASCULAR
		Do you have only one of a paired organ (eye, kidney,			CHEST / LUNGS
		Are you able to run around the track twice without			ABDOMEN
		Dizziness or passing out during exercise?			SKIN
		Asthma, chest pain, hay fever, or coughing during			HERNIA - MALES
		Do you wear glasses, contacts, dental bridges, or			NECK, SPINE/SCOLIOSIS
		Do you take any medication or pills?			UE: ROM/STRENGHT
		Are you allergic to any medication?			LE: ROM/STRENGHT
		Have you ever had surgery or been hospitalized?			KNEES
		doctor?			ANKLES
		Do you take vitamin or health aids to improve your performance?			
		Do you have any trouble trying to stop bleeding?			
		Do you have anything you wish to discuss with your doctor?			

Explain Anything Marked as "Y" or "Abnormal":

Fill If Any LABS Assessment: No Problem Identified Other:

RECOMMENDATIONS:	Qualified for all sports/activities (including contact/collision)
	Qualified for non-contact sports (specify):
	Patient needs Pysician follow-up - Not eligible for Sports Participation at this time

PHYSICIANS SIGNATURE:	DATE PHYSICAL CONDUCTED:
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