

# Sports Physical Evaluation: Dexter

NAME: \_\_\_\_\_

MALE/FEMALE (Circle One)

AGE: \_\_\_\_\_ GRADE: \_\_\_\_\_

Circle the sports you play:

DATE OF BIRTH: \_\_\_\_\_

- |              |               |                 |
|--------------|---------------|-----------------|
| Baseball     | Basketball    | Football        |
| Cheerleading | Dance         | Track           |
| Softball     | Cross Country | Volleyball      |
| Wrestling    | Golf          | Swimming/Diving |
| Soccer       | Tennis        | Water Polo      |
| Lacrosse     | Field Hockey  | Rugby           |
| Other: _____ |               |                 |

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

**Instructions:** Please review all of the questions below and answer them as truthfully as possible. It is important to include all pertinent information **Parents or guardians must sign below.**

- |   | <u>YES</u> | <u>NO</u> | <u>EXPLAIN</u> |
|---|------------|-----------|----------------|
| 1. Has anyone in your family died suddenly before the age of 50?                          | _____      | _____     |                |
| 2. Have you ever passed out or felt dizzy during exercise?                                | _____      | _____     |                |
| 3. Do you have asthma or allergies?   | _____      | _____     |                |
| 4. Have you ever broken a bone, worn a cast, or injured a joint? (i.e., an ankle or knee) | _____      | _____     |                |
| 5. Have you ever been knocked-out (concussion)?   | _____      | _____     |                |
| 6. Do you have a chronic illness or see a doctor regularly?                               | _____      | _____     |                |
| 7. Do you have only one of any normally paired organ? (ie, eyes, kidneys, etc.)           | _____      | _____     |                |
| 8. Do you consider your weight ideal?<br>If no, write your ideal weight. _____lbs.        | _____      | _____     |                |
| 9. Do you take any medications regularly?   | _____      | _____     |                |
| <b>FOR WOMEN ONLY:</b>  |            |           |                |
| 10. Do you have regular periods?  | _____      | _____     |                |
| 11. How old were you when you had your first period? _____ years                          |            |           |                |
| 12. How many periods did you have during the last 12 months? _____                        |            |           |                |

I have reviewed the above questions with my son/daughter and I give permission for my child to undergo the Pre participation Physical Examination and to participate in sports.

I hereby give my consent for the above student to engage in interscholastic athletics and for the disclosure to the MHSAA of information otherwise protected by FERPA and HIPAA for the purpose of determining eligibility for interscholastic athletics; and I understand the possibility that serious injury may result from participating in athletic activities. He/she has my permission to accompany the team as a member on its out-of-town trips. I further understand that my son/daughter will be expected to adhere firmly to all established athletic policies of the school district and the Michigan High School Athletic Association.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

HEALTH INSURANCE: \_\_\_\_\_ PREF. HOSPITAL \_\_\_\_\_

**THIS FORM MUST BE ON FILE IN THE SCHOOL OFFICE  
BEFORE PRACTICING WITH ANY ATHLETIC TEAM.**

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# PHYSICAL EXAMINATION

Physicians: Please complete all the information below.

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Vision: \_\_\_\_\_ (R) 20/ \_\_\_\_\_ (L) 20/ \_\_\_\_\_

(B) 20/ \_\_\_\_\_ Corrected Y/N (circle one)

Vision Reference Range: Is corrected or uncorrected vision better than 20/50 with both eyes?

Blood Pressure: \_\_\_\_\_ BP Reference Range:  
10-12 y/o > 125/80  
13-15 y/o > 135/85  
16-18 y/o > 140/90

<u>Cardiopulmonary Examination:</u>	<u>Normal</u>	<u>Abnormal</u>	<u>Explain</u>
Lungs	_____	_____	
Pulses	_____	_____	
Heart	_____	_____	

<u>Musculoskeletal Screening:</u>		
Neck	_____	_____
Shoulder	_____	_____
Elbow	_____	_____
Wrist	_____	_____
Hand	_____	_____
Back	_____	_____
Knee	_____	_____
Ankle	_____	_____
Foot	_____	_____

Other: (Physical examination pertinent to historical information)

Recommendation:

- \_\_\_\_\_ 1. Pass
- \_\_\_\_\_ 2. Pass with restrictions: \_\_\_\_\_
- \_\_\_\_\_ 3. Deferred until: \_\_\_\_\_
- \_\_\_\_\_ 4. Failed, Reason: \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date: \_\_\_\_\_