Sports Physical Form

Athlete's full name: Draymond E. Bronson Date of birth: 1/21/2000

Age: 19 Sex: Male Address: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Contact number: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX Email address: xxxxxxxxxxxxxxxxxxxxxxx@xxxxx.com

Sport: Basketball

Date of form submission: 3/18/2019

If you're a student:

School: xxxxxxxxxxxxxxxxxxxxxxx College Grade: Sophomore

Father's name and contact details: Janice E. Bronson

Mother's name and contact details: Andre G. Bronson

If you're a professional athlete:

Sports team: n/a

Emergency contact: n/a

Questions	Yes	No
1. Has a doctor ever restricted/denied your participation in sports?	☐	☑
2. Have you ever been hospitalized or spent a night in a hospital?	☐	☑
3. Have ever had surgery?	☐	☑
4. Do you have any ongoing medical conditions (like Diabetes or Asthma)?	☐	☑
5. Are you presently taking any medications or pills (prescription or over-the-counter?	☐	☑
6. Do you have any allergies (medicine, pollens, foods, bees or other stinging insects)?	☐	☑
7. Have you ever passed out during or after exercise?	☐	☑
8. Have you ever been dizzy during or after exercise?	☐	☑
9. Have you ever had chest pain or discomfort in your chest during or after exercise?	☐	☑
10. Do you tire more quickly than your friends during exercise?	☐	☑
11. Have you ever had high blood pressure?	☐	☑
12. Have you ever been told that you have a heart murmur, high cholesterol, or heart infection?	☐	☑
13. Have you ever had a racing of your heart or skipped heartbeats?	☐	☑
14. Has anyone in your family died of heart problems or sudden death before age 50?	☐	☑
15. Does anyone in your family have a heart condition?	☐	☑
16. Has a doctor ever ordered a test on your heart (EKG, echocardiogram)?	☐	☑
17. Do you have any skin problems (itching, rashes, staph, MRSA, acne)?	☐	☑
18. Have you ever had a head injury or concussion?	☐	☑

Questions	Yes	No
19. Have you ever been knocked out or unconscious?	☐	☑
20. Have you ever had a seizure?	☐	☑
21. Have you ever had a stinger, burner, pinched nerve, or loss of feeling, or weakness in your arms or legs?	☐	☑
22. Have you ever had heat or muscle cramps?	☐	☑
23. Have you ever been dizzy or passed out in the heat?	☐	☑
24. Do you have trouble breathing or do you cough during or after activity?	☐	☑
25. Do you take any medications for asthma (for instance, inhalers)?	☑	☐
26. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)?	☐	☑
27. Have you had any problems with your eyes or vision?	☐	☑
28. Do you wear glasses or contacts or protective eyewear?	☐	☑
29. Have you had any other medical problems (infectious mononucleosis, diabetes, infectious diseases, etc.)?	☐	☑
30. Have you had a medical problem or injury since your last evaluation?	☐	☑
31. Have you ever been told you have sickle cell trait?	☐	☑
32. Has anyone in your family had sickle cell disease or sickle cell trait?	☐	☑
33. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints? ☐ Head ☐ Back ☐ Shoulder ☐ Forearm ☐ Hand ☐ Hip ☐ Knee ☐ Ankle ☐ Neck ☐ Chest ☐ Elbow ☐ Wrist ☐ Finger ☐ Thigh ☐ Shin ☐ Foot	☐	☑
34. When was your first menstrual period? n/a		
35. When was your last menstrual period? n/a		
36. What was the longest time between your periods last year? n/a		

Please note that your physician will ask you about the items you answered Yes to during the examination.

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

Signature of athlete: xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx Date: 3/18/2019

Signature of parent/guardian (if student): xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Physical Examination

Height: 6"1 **Weight:** 205 lbs **Pulse:** 70bpm **Blood Pressure:** 120/80

Vision: R 20 / 20, L 20 / 20 **Vision Corrected:** ☐ Yes ☑ No

	Normal	Abnormal Findings
Cardiovascular	Normal	
Pulses	Normal	
Heart	Normal	
Lungs	Normal	
Skin	Normal	
E.N.T.	Normal	
Abdominal	Normal	
Genitalia (males)	Normal	
Musculoskeletal	Normal	
Neck	Normal	
Shoulder	Normal	
Elbow	Normal	
Wrist	Normal	
Hand	Normal	
Back	Normal	
Knee	Normal	
Ankle	Normal	
Foot	Normal	
Other	Normal	

Clearance:

☑ A. Cleared
☐ B. Cleared after completing evaluation/rehabilitation for: n/a
☐ C. Not cleared

Due to: n/a

Recommendation: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Name of physician: Cruise Elroy Date: 3/25/2019

Address: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX Phone: XXXXXXXXXX

Signature of physician: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX , M.D. or D.O.