



Chadron State Athletics

Physical Exam Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Today's Date \_\_\_\_\_ Sport: \_\_\_\_\_ Age (years): \_\_\_\_\_

Does the student-athlete suffer from a medical condition of which the CSC should be aware? \_\_\_\_ Yes \_\_\_\_ No If yes, please list:

Is the student-athlete currently taking any medications? \_\_\_\_ Yes \_\_\_\_ No If yes, please list:

Does the student-athlete have asthma? \_\_\_\_ Yes \_\_\_\_ No If yes, please answer the following:

Does the student-athlete use an inhaler/nebulizer? \_\_\_\_ Yes \_\_\_\_ No

Does the student-athlete have any allergies (food, bee stings, medications, etc.) \_\_\_\_ Yes \_\_\_\_ No If yes, please list:

Does the student-athlete have a history of passing out due to exercise or had an immediate family member die suddenly due to a heart related condition before the age of 50? \_\_\_\_ Yes \_\_\_\_ No If yes, please explain:

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Pulse (bpm): \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

Check off normal finding and indicate abnormal findings and where follow-up is recommended.

Table with 4 columns: System, Normal, Abnormal Findings, Needs Follow-Up. Rows include Appearance, Eyes/Ears/Nose/Throat, Heart, Lungs, Abdomen, Genitourinary (males), Skin, Musculoskeletal (Neck, Spine), Upper Extremities (Shoulders/Elbows/Wrists), Lower Extremities (Hips/Knees/Feet/Ankles).

I certify that the above named student-athlete is (check one):

\_\_\_\_ cleared to participate \_\_\_\_ cleared, but restricted \_\_\_\_ NOT cleared to participate at all

Physician's Signature: \_\_\_\_\_ Date \_\_\_\_\_

Physician's Printed Name: \_\_\_\_\_

Physician's Street Address: \_\_\_\_\_

Physician's City, State Zip: \_\_\_\_\_

Physician's Phone Number: \_\_\_\_\_