

MOTHER LODE YOUTH ATHLETIC CONFERENCE

The American Academy of Family Physicians
Athletic Competition Health Screening Form

PLAYER/CHEERLEADER

LAST NAME	FIRST NAME	AGE
ELEMENTARY SCHOOL ATTENDING	DATE OF BIRTH	SEX

PARENT/GUARDIAN (To Be Completed By Parent/Guardian)

NAME
ADDRESS
PHONE

PHYSICIAN (To Be Completed By Physician)

NAME
ADDRESS
PHONE

Answer Yes or No Only	Yes	No
Chronic/Recurrent Illness?		
Hospitalization?		
Surgery other than tonsils?		
Injuries treated by physician?		
Current medications?		
Organs missing?		
Heat exhaustion/stroke?		
Dizziness, fainting, convulsions and/or headaches?		
Knocked out?		
Concussion?		
Wear glasses or contacts?		
Hearing defects?		
Dental appliances-bridge, braces, cap, plate?		
Cough/pain?		
Problems with blood pressure, heart or murmurs?		
Problems with liver, spleen or kidney?		
Hernia?		
Recurrent skin disease?		
Bone/joint injury?		
Sprain/dislocation?		
Injury that caused a missed practice or event?		
Allergies?		
Allergies to medications?		
Other allergies?		
Tetanus booster in last 10 years?		

THE INFORMATION PROVIDED ABOVE IS CURRENT
AND TRUE TO THE BEST OF MY KNOWLEDGE

Vitals	SATISFACTORY		Physical Evaluation Comments	Recommended Follow Up
	Yes	No		
Height				
Weight				
BP: _____				
General				
Head				
Eyes			Acuity: L R	
Ent				
Dental				
Chest				
Heart				
Abdomen				
Genitalia				
Skin				
Extremities				
Back/Neck				

SPORT PARTICIPATION APPROVED: Yes No

Limitations: _____

Comments: _____

PARENT/GUARDIAN SIGNATURE DATE

PHYSICIAN SIGNATURE DATE