



# HEALTH OFFICE

**OTTER VALLEY UNION HIGH SCHOOL**  
**2997 FRANKLIN STREET**  
**BRANDON, VERMONT 05733**  
**247-6833 X247 FAX 247-4627**

Physical Examination for  
Competitive Sports

STUDENT'S NAME \_\_\_\_\_ M/F \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ GRADE \_\_\_\_\_  
PARENT/GUARDIAN \_\_\_\_\_ PHONE# \_\_\_\_\_  
STREET ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_  
SPORTS PARTICIPATING IN \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_

**INSTRUCTIONS FOR PARENTS & STUDENTS: Please answer the following questions before presenting this form to the physician for a sport physical.**

1. Have you ever been told you could not participate in a sport and why? Yes No
2. Have you ever been unconscious or lost memory from a blow to the head? Yes No
3. Have you had a fracture or dislocation in the last two years? Yes No
4. Have you had a knee or ankle sprain in the last two years? Yes No
5. Have you had any other injuries? Describe Yes No
6. Are you under a physician's care now? For what? Yes No
7. Have you had an illness/injury lasting more than a week in the last six months? Yes No  
Please explain.
8. Have you been in the hospital for an operation or to stay overnight? Yes No
9. Have you ever felt faint or fainted during exercise? Yes No
10. Has any family member suffered a heart attack before the age of 50? Yes No
11. Do you have any worries about your health or questions you would like to discuss with a Physician? Yes No

**INSTRUCTIONS TO PHYSICIANS: This student is about to enter a program of strenuous activity. A physical exam is required every two years. Please review the sports questionnaire filled out by the student and parent and note the possible disqualifying conditions.**

1. CONDITIONS WHICH MAY ACT AS DISQUALIFIERS:
  - a. Enlargement of spleen after mononucleosis
  - b. Bleeding Disorder
  - c. Asthma during acute episodes or exercise induced asthma not controlled by medication
  - d. Acute or chronic strains and sprains of joints
  - e. Epilepsy if not well controlled by medication
  - f. Persistent hypertension not controlled by medication/ salt restriction
  - g. Acute infection until fever-free for 48 hours
  
2. CONDITIONS WHICH MAY DISQUALIFY STUDENTS FROM STRENUOUS SPORTS:
  - a. Physical signs suggestion mitral or aortic stenosis
  - b. Coarctation of the aorta, prolapse or mitral valve, or post infectious carditis- need evaluation of cardiologist
  - c. Ectopic beats that do not disappear when pulse rate goes about 140 with exercise- need evaluation of cardiologist
  
3. CONDITIONS WHICH MAY DISQUALIFY STUDENT FROM CONTACT/COLLISION SPORT
  - a. Loss of paired organ- eye, kidney, testicle
  - b. Previous retinal detachment
  - c. Sever strain or sprain that has not been evaluated within three months to contact sport
  - d. Concussion- one concussion- removed from the game
    - Two concussions disqualify for season
    - Three concussions- need evaluation by neurosurgeon before participating again

STUDENT'S NAME: \_\_\_\_\_

**TO THE PHYSICIAN: PLEASE REVIEW THE HEALTH QUESTIONS ON THE REVERSE SIDE**

Height \_\_\_\_\_ Percentile \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Weight \_\_\_\_\_ Percentile \_\_\_\_\_ Last Tetanus Toxoid \_\_\_\_\_

General Appearance: Muscular, Slender, Obese

	Normal	Abnormal(Explain)
Eye – Vision bilateral, glasses appropriate for sport, contact lenses?	_____	_____

Ears – Hearing bilateral (any perforation?)	_____	_____
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Nose – Septal deviation	_____	_____
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Mouth – Caps, loose teeth, orthodontic appliances	_____	_____
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Neck – Range of motion, thyroid	_____	_____
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Lungs – Aeration, abnormal sounds	_____	_____
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Heart – Size, rhythm, murmurs	_____	_____
Heart rate should be monitored after predetermined stress		

Abdomen – Enlarged liver/spleen, masses, hernia, bruits	_____	_____
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Genitalia – Testes – size – one or two, varicocele	_____	_____
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Spine – flexibility – scoliosis	_____	_____
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Extremities – strength – flexibility		
Range of motion, joint/ligament stability		
Swelling – deformity, peripheral pulses	_____	_____

Neurological – alert		
Cranial nerve function, peripheral nerve function	_____	_____

Other: \_\_\_\_\_

I feel this student can participate in the sport of choice providing he/she can pass the physical fitness test for that sport.

DATE OF PHYSICAL \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF HEALTH CARE PROVIDER

\_\_\_\_\_  
PRINT NAME HEALTH CARE PROVIDER