OHIO STATE YOUTH FOOTBALL LEAGUE
Elyria Youth Football Association

MEDICAL PHYSICAL EXAMINATION
ANNUAL ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION FORM

Part A: HEALTH HISTORY QUESTIONNAIRE

Today's Date: ____________________ Date of Last Sports Physical: __________________________

Student's Name: __________________________________ Sex: M F (circle one) Age: ____ Grade: ________
Date of Birth: ____/___/_______ School: _____________________________ District: _______________________
Sport(s): ____ Home Phone: (_____) ___________
Provider Name (Medical Home): _______________________________ Phone: _______________________ Fax: ____________

EMERGENCY CONTACT INFORMATION

Name of parent/guardian: _________________________________ Relationship to student: ______________________________
Phone (work): _____________________ Phone (home):______________________________ Phone (cell): _________________
Additional emergency contact: ______________________________ Relationship to student: ______________________________
Phone (work): _____________________ Phone (home):______________________________ Phone (cell): _________________

Directions: Please answer the following questions about the student's medical history by CIRCLING the correct response. Explain all "yes" responses on the lines below the questions. Please respond to all questions.

1. Have you ever had, or do you currently have:
   - a. Restriction from sports for a health related problem? Y / N / Don't Know
   - b. An injury or illness since your last exam? Y / N / Don't Know
   - c. A chronic or ongoing illness (such as diabetes or asthma)? Y / N / Don't Know
     - (1.) An inhaler or other prescription medicine to control asthma? Y / N / Don't Know
   - d. Any prescribed or over the counter medications that you take on a regular basis? Y / N / Don't Know
   - e. Surgery, hospitalization or any emergency room visit(s)? Y / N / Don't Know
   - f. Any allergies to medications? Y / N / Don't Know
   - g. Any allergies to bee stings, pollen, latex or foods? Y / N / Don't Know
     - (1.) If yes, check type of reaction:
       ☐ Rash ☐ Hives ☐ Breathing or other anaphylactic reaction
     - (2.) Take any medication/Epipen taken for allergy symptoms? (List below.) Y / N / Don't Know
   - h. Any anemias, blood disorders, sickle cell disease/trait, bleeding tendencies or clotting disorders? Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):
____
____
____

List all medications here:

Medication Name	Dosage	Frequency

2. Have you ever had, or do you currently have, any of the following head-related conditions:
   - a. Concussion or head injury (including "bell rung" or a "ding")? Y / N / Don't Know
   - b. Memory loss? Y / N / Don't Know
   - c. Knocked out? Y / N / Don't Know
   - c. A seizure? Y / N / Don't Know
   - d. Frequent or severe headaches (With or without exercise)? Y / N / Don't Know
   - e. Fuzzy or blurry vision Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):
____
____
____

3. Have you ever had, or do you currently have, any of the following heart-related conditions:
   a. Restriction from sports for heart problems? Y / N / Don't Know
   b. Chest pain or discomfort? Y / N / Don't Know
   c. Heart murmur? Y / N / Don't Know
   d. High blood pressure? Y / N / Don't Know
   e. Elevated cholesterol level? Y / N / Don't Know
   f. Dizziness or passing out during or after exercise without known cause? Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):
____
____
____

4. Have you ever had, or do you currently have, any of the following eye, ear, nose, mouth or throat conditions:
   a. Vision problems? Y / N / Don't Know
      (1.) Wear contacts, eyeglasses or protective eye wear? (Circle which type.) Y / N / Don't Know
   b. Hearing loss or problems? Y / N / Don't Know
      (1.) Wear hearing aides or implants? Y / N / Don't Know
   c. Nasal fractures or frequent nose bleeds? Y / N / Don't Know
   d. Wear braces, retainer or protective mouth gear? Y / N / Don't Know
   e. Frequent strep or any other conditions of the throat (e.g. tonsillitis)? Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):
____
____
____

5. Have you ever had, or do you currently have, any of the following neuromuscular/orthopedic conditions:
   a. Numbness, a "burner", "stinger" or pinched nerve? Y / N / Don't Know
   b. A sprain? Y / N / Don't Know
   c. Swelling or pain in muscles, tendons, bones or joints? Y / N / Don't Know
   d. Dislocated joint(s)? Y / N / Don't Know
   e. Upper or lower back pain? Y / N / Don't Know
   f. Fracture(s), stress fracture(s), or broken bone(s)? Y / N / Don't Know

Explain all (yes) answers here (include relevant dates):
____
____
____

6. Have you ever had or do you currently have any of the following general or exercise related conditions:
   a. Difficulty breathing?
      (1.) During exercise? Y / N / Don't Know
      (2.) After running one mile? Y / N / Don't Know
      (3.) Coughing, wheezing or shortness of breath in weather changes? Y / N / Don't Know
      (4.) Exercise-induced asthma? Y / N / Don't Know
         i. Controlled with medication? (specify ____________________________) Y / N / Don't Know
   b. Become tired more quickly than others? Y / N / Don't Know
   c. Any of the following skin conditions:
      (1.) Cold sores/herpes, impetigo, MRSA, ringworm, warts? Y / N / Don't Know
      (2.) Sun sensitivity? Y / N / Don't Know
   d. Ever had feelings of depression? Y / N / Don't Know
   e. Heat-related problems (dehydration, dizziness, fatigue, headache)? Y / N / Don't Know
      (1.) Heat exhaustion (cool, clammy, damp skin)? Y / N / Don't Know
      (2.) Heat stroke (hot, red, dry skin)? Y / N / Don't Know
      (3.) Muscle cramps? Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):
____
____
____

PARENT/GUARDIAN SIGNATURE

I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature.

____ ____________________

Signature, Parent/Guardian or Student Age 18 **Date of Signature**

Print Name of Person Above:______________________________

Part B: Physical Evaluation Form
(Completed by the examining licensed provider MD, DO or RN)

-STUDENT INFORMATION-

Student's Name: ____________________________________ Sport(s): ____
Sex: M F (circle one) Age: ________ Grade: _____________ Date of Birth: ____
Address: ____
City/State/Zip:____ Home Phone: ____
School: ____ District: ____
Parent/Guardian's Full Name: ____

- EXAMINING PHYSICIAN/PROVIDER CONTACT INFORMATION-

Name: _________________________________ Phone: ____________________________ Fax: __________________
Address:_________________________________ City/State/Zip:____

- FINDINGS OF PHYSICAL EVALUATION -

Height: _________ Weight: _________ Blood Pressure: ______/_______ Pulse: _____bpm.
Vision: R 20/____ L 20/ ____ Corrected: Y / N Contacts: Y / N Glasses: Y / N

INDICATORS	NORMAL?	ABNORMAL FINDINGS/COMMENTS
General Appearance	YES	
Head/Neck	YES	
Eyes/Sclera/Pupils	YES	
Ears	YES	
Gross Hearing	YES	
Nose/Mouth/Throat	YES	
Lymph Glands	YES	
Cardiovascular	YES	
Heart Rate	YES	
Rhythm	YES	
Murmur	ABSENT	
Femoral Pulses	YES	
Lungs: Auscultation/Percussion	YES	
Chest Contour	YES	
Skin	YES	
Abdomen (liver, spleen, masses)	YES	
Assessment of physical maturation or Tanner Scale	YES	
Testicular Exam (Males Only)	YES	
Neck/Back/Spine:	YES	
Range of Motion	YES	
Scoliosis	ABSENT	
Upper Extremities: (ROM, Strength, Stability)	YES	
Lower Extremities: (ROM, Strength, Stability)	YES	
Neurological: Balance & Coordination	YES	

Most recent immunizations and dates administered:
____
____

Additional observations:
____
____

General Recommendations:
____
____

CLEARANCES: (See notes at bottom for conditions requiring attention and for a list of sports by level of contact)

☐ A. Student is cleared for participation in all sports without restriction.

☐ B. Student is withheld clearance for participation in any sport until evaluation / treatment of: ______________________________

MEDICAL PROFESSIONAL License Type: MD ☐ DO ☐ RN ☐

SIGNATURE: ____ Examination Date: ______________