The American Academy of Family Physicians
Athletic Competition Health Screening Form

ATHLETE

LAST NAME | FIRST NAME | AGE

ELEMENTARY SCHOOL ATTENDING | DATE OF BIRTH | SEX

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

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

PARENT/GUARDIAN SIGNATURE | DATE

PHYSICIAN *(To Be Completed By Physician)*

NAME

ADDRESS

PHONE

Vitals	SATISFACTORY Yes	SATISFACTORY No	Physical Evaluation Comments	Recommended Follow Up
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: _____

PHYSICIAN SIGNATURE | DATE