DELTA HEALTH CARE TEEN SERVICES
SPORTS PHYSICAL FORM
SUSD ATHLETES

Sex: M F

Name: _____ **Birthdate**: _____ **Age**: _____

Address: _____ **Zip**: _____

Phone: _____ **Grade**: _____ **Student ID #**:_____

What Race do you consider yourself to be? White Black/African American Asian
American Indian/Alaska Native Native Hawaiian/Pacific Islander
Do you consider yourself to be of Hispanic/Latino origin? Yes No

Name of Parent / Guardian: _____

Name of Family Doctor: _____

Sport: _____

HEALTH HISTORY

YES	***NO***	**HAVE YOU HAD ANY OF THE FOLLOWING:**	***YES***	***NO***	**ANY HISTORY OF:**
____	____	Surgery?	____	____	Knee pain or injury?
____	____	Chronic or recurrent illness?	____	____	Injuries requiring doctor's care?
____	____	Hospitalizations?	____	____	Neck or back pain or injury?
____	____	Missing organs (kidney, eye, testicle)?	____	____	Shoulder or elbow injury?
____	____	Allergies?	____	____	Ankle injury?
____	____	Problems with heart or blood pressure?	____	____	Broken bones?
____	____	Chest pain?	____	____	Shortness of breath / wheezing?
____	____	Dizziness or fainting?	____	____	Headaches?
____	____	Concussion or loss of consciousness?	____	____	Heat exhaustion / heat stroke?
____	____	Do you have asthma?	____	____	Seizures and convulsions?

(For Females Only) Date of last menstrual period: _____

Do you wear eye glasses or contact lenses?	Yes	No
Do you take any medications routinely?	Yes	No
Do you smoke cigarettes?	Yes	No
Do you use recreational drugs?	Yes	No

Please explain any "YES" answers here: _____

_____

_____

Parent/Guardian Signature: _____ Date: _____