

Students Off And Running
Physical Screening Form
2026-2027 Training
Season Physical Deadline:
12/11/26

Student Name:

(please print)

Birth Date:

School/Group:

Phone Number:

Age: _____ **Gender:** _____

Parent/Guardian must complete all the information down to **the black line and sign** below before student is examined.

I, (print name) _____, give my consent on behalf of my son/daughter, or the minor for whom I am legal guardian, to participate in and receive a physical screening exam. This exam may include an unclothed exam by a licensed health provider as well as urine, vision, & blood pressure screening. I understand that this exam is intended for the purpose of screening for participation in Students Off And Running and does not take the place of a physical exam provided by the student's primary health provider. I also consent to the release of information by the screening institution to the administrative care of Student's Off And Running.

Parent/Guardian Signature: _____ **Date:** _____

Medical History: 'Yes' answers to the following questions must be answered in detail and include date(s). Use reverse side if necessary. Parent/Guardian **must** answer all questions.

1. Have you ever sustained an injury, which prevented you from playing sports for more than one day? ___ Yes ___ No

2. Have you had any of the following injuries? (check all that apply)

___ Skull fracture ___ Brain surgery ___ Concussion ___ Knocked out ___ Ligament Sprain/Strain ___ Neck pain/Injury
___ Broken bone ___ Back pain ___ Back injury ___ Fainting ___ Tender knee cap/Shin ___ Arm/Finger numbness
___ Numb leg/Toe ___ Heat stroke ___ Exhaustion ___ Knee locking ___ Joint dislocation ___ Muscle pull/Locking
___ Deep Bruise ___ Sprains/Strains ___ Other: _____

3. Do you have a history of and/or take medication (specify) for any medical problem such as: (check all that apply)

___ Chest pain when exercising, ___ Asthma, ___ Allergy, ___ Wheezing, ___ Short of breath, ___ Heart murmur, ___ Palpitation, ___ Rheumatic fever,
___ High blood pressure, ___ Diabetes,
___ Fainting, ___ Seizure, ___ Yellow jaundice, ___ Hepatitis, ___ Severe Flu/Cold, ___ Mononucleosis, ___ Weakness, ___ Anemia, ___ Bruise easily,
___ Bleeding, ___ Sickle Cell, ___ Loss of eyesight, ___ Hearing, ___ Testicle bruise, ___ Kidney, ___ Hernia, ___ Rupture, ___ Skin disease, ___ Boils,
___ Rash, or Other: _____

4. Are you allergic to any medication such as (circle) Penicillin, Iodine, Novacaine, or other medications? _____

5. Any family history of medically unexplained or cardiac caused sudden death under age 50? ___ Yes ___ No

6. Any family history of Long QT Syndrome or unexplained fainting or seizures? ___ Yes ___ No

For Physician Use Only -

History O.K. () Height: _____ Weight: _____ B/P: _____ Pulse: _____ Temp: _____ Resp: _____

General Appearance: () well nourished and well developed

Neuro: () N () Ab _____ Back: () N () Ab _____

Head: () N () Ab _____ Arm abduct: () N () Ab _____

Eyes: () N () Ab _____ Arm ext. rot. () N () Ab _____

Ears: () N () Ab _____ Pro/sup wrist: () N () Ab _____

Neck: () N () Ab _____ Flex/ext. elbow: () N () Ab _____

Shoulder Shrug: () N () Ab _____ Sprd Fingers/fist: () N () Ab _____

Heart: () N () Ab _____ Patellar reflex: () N () Ab _____

Lungs: () N () Ab _____ Achilles Refelx: () N () Ab _____

Abd: () N () Ab _____ Quads cont/relacx: () N () Ab _____

Hernia: () N () Ab _____ Females Only – Most recent menstrual period: _____

Impression:

() **Satisfactory Screening Exam** () **Recommend Further Evaluation:** 1) Reason: _____
2) May continue to train? ___ Yes ___ No

Physician Signature: _____ Physician Name (print): _____ Date: _____

*****The exam must have a DATE and PHYSICIAN STAMP and SIGNATURE.*****