american family care®
URGENT CARE

1295 S Colorado Blvd
Denver, CO 80206
Phone: 303-639-1000 | Fax: 720-420-9933
Monday - Friday: 8:00 AM - 8:00 PM
Saturday & Sunday: 8:00 AM - 6:00 PM

Student Physical Examination Form

Please print and fill-out this form completely on both sides.

Student's Name: _____ Student's Grade: _____

Age: _____ Date of Birth: ___/___/___ Home Phone: _____ Sport: _____

Father's name: _____ Mother's Name: _____

Height: _____ Weight: _____ BP ___/___ Resting Pulse: _____ Vision: R 20/___ L 20/___ Corrected? ❑ Y ❑ N

Area	Comments	Initials
Head & Scalp		
Ears		
Nose & Sinus		
Throat, Tonsils, & Adenoids		
Thyroid		
Chest/Lungs		
Respirations		
Cardiovascular		
Heart Rate		
Rhythm		
Murmurs		
Other		
Abdomen		
Scar, Tenderness, or Masses		

Area	Comments	Initials
Hernia		
Paired & Functioning Organs		
Musculoskeletal		
Spine/Posture		
Shoulders		
Lower Arm, Hand, & Fingers		
Torso: Posture		
Lower Body: Knee, Ankles, Feet		
Skin		
Central Nervous System		
Pupil Response		
Reflexes		
Coordination		

CLEARANCE

THIS SECTION MUST BE COMPLETED, SIGNED, AND STAMPED BY THE ATTENDING PRACTITIONER

Cleared for full physical Activity: ❑ **Yes** ❑ **No**

If no, explain: _____

_____

_____

_____

_____

Signature of Practitioner: _____ **Date of Exam:** _____

continued

HISTORY

Preparticipation Physical Examination

Date of Exam: ____/____/____

Explain "Yes" answers below. Circle questions you don't know the answer to.

	Yes	No
1. Has a doctor ever restricted your participation in sports for any reason?	❑	❑
2. Do you have an ongoing medical condition? *(Like diabetes or asthma)*	❑	❑
3. Are you currently taking any prescription over-the-counter medicines or pills?	❑	❑
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	❑	❑
5. Have you ever passed out or nearly passed out DURING exercise?	❑	❑
6. Have you ever passed out or nearly passed out AFTER exercise?	❑	❑
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	❑	❑
8. Does your heart race or skip beats during exercise?	❑	❑
9. Has your doctor ever told you that you have:		
(Check all that apply): ❑ High Blood Pressure ❑ A Heart Murmur ❑ High Cholesterol ❑ A Heart Infection		
10. Has a doctor ever ordered a test for your heart? *(ex ECG, echocardiogram)*	❑	❑
11. Has anyone in your family died for no apparent reason?	❑	❑
12. Does anyone in your family have a heart problem?	❑	❑
13. Has a family member died of heart problems before the age of 50?	❑	❑
14. Does anyone in your family have Marfans Syndrome?	❑	❑
15. Have you ever spent the night in a hospital?	❑	❑
16. Have you ever had surgery?	❑	❑
17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis that caused you to miss a game/practice? *If yes, circle affected area below.*	❑	❑
18. Have you ever had any broken or fractured bones or dislocated joints? *If yes, circle affected area below.*	❑	❑
19. Have you ever had an injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? *If yes, circle affected area below.*	❑	❑

Head	Elbow	Upper Back	Knee
Neck	Forearm	Lower Back	Calf/Shin
Shoulder	Hand/Fingers	Hip	Ankle
Upper Arm	Chest	Thigh	Foot/Toes

20. Have you ever had a stress fracture?	❑	❑
21. Have you had an x-ray for atlantoaxial (neck) instability?	❑	❑

	Yes	No
22. Do you regularly use a brace or assistive device?	❑	❑
23. Has a doctor ever told you that you have asthma or allergies?	❑	❑
24. Do you cough, wheeze, or have difficulty during or after exercise?	❑	❑
25. Is there anyone in your family with asthma?	❑	❑
26. Have you ever used an inhaler or taken asthma medicine?	❑	❑
27. Were you born without/are you missing a kidney, eye, testicle, or other organ?	❑	❑
28. Have you had infectious mononucleosis (mono) within the last month?	❑	❑
29. Do you have any rashes, pressure sores, or other skin problems?	❑	❑
30. Have you ever had a herpes skin infection?	❑	❑
31. Have you had a head injury/concussion?	❑	❑
32. Have you been hit in the head & been confused or lost memory?	❑	❑
33. Have you ever had a seizure?	❑	❑
34. Do you have headaches with exercise?	❑	❑
35. Have you ever had numbness, tingling, or weakness in arms or legs after being hit?	❑	❑
36. Have you ever been unable to move arms after being hit?	❑	❑
37. When exercising in the heat, do you have severe muscle cramps or become ill?	❑	❑
38. Has a doctor ever told you that you or a family member has sickle cell trait/disease?	❑	❑
39. Have you had eye or vision problems?	❑	❑
40. Do you wear glasses/contacts?	❑	❑
41. Do you wear protective eyewear, such as goggles or a face shield?	❑	❑
42. Are you happy with your weight?	❑	❑
43. Are you trying to lose or gain weight?	❑	❑
44. Has anyone recommended you change your weight or eating habits?	❑	❑
45. Do you limit what you eat?	❑	❑
46. Do you have any concerns you want to discuss with the doctor?	❑	❑

Explain "Yes answers here: _____

_____

_____

_____

_____

Notice to Patients/Parents:
Because American Family Care has limited access to your complete medical history, the sports physical performed today should not be considered comprehensive. You should always consult with your primary care physician and share the results of our examination with them. If there are any concerns regarding the results of your examination today, you should consult with your primary care physician before engaging in any strenuous activities.

I hereby state that the above answers, to the best of my knowledge, are complete and correct.

Athlete's Signature: _____ Date: ____/____/____

Parent or guardian's signature: _____ Date: ____/____/____

Notice to Patients/Parents:

Because American Family Care (AFC) has limited access to your complete medical history, the sports physical performed today should not be considered comprehensive. You should always consult with your primary care physician and share the results of our examination with them. If there are any concerns regarding the results of your examination today, you should consult with your primary care physician before engaging in any strenuous activities.

_____

Athlete's Signature Date

_____

Parent or guardian's signature Date

Consent Form for Treatment of Minor Child

I, _____ (name of parent/guardian), hereby authorize AFC Urgent Care Denver and their providers to administer necessary medical care to _____(Child's name).

Name of Child: _____ **Sex**: M F **DOB**: _____/_____/_____

Signature: _____ **Date**: _____/_____/_____

Printed Name: _____

Witnessed By: _____

Printed Name: _____