

**HEART OF CHAMPIONS BOXING
PHYSICAL FORM**

PRE-PARTICIPATION ATHLETIC PHYSICAL EXAMINATION

Athlete Name: _____

Age: _____

Sport: _____

Phone: _____

STEP ONE: Health History (to be completed by athlete):

Circle the appropriate answer (explain "" below):

Do you have any allergies?	Yes	No
Do you take any medicines?	Yes	No
Have you ever had a heart murmur?	Yes	No
Have you ever had an irregular heartbeat?	Yes	No
Has anyone in your family died prior to age 40?	Yes	No
Have you ever been hospitalized overnight?	Yes	No
Have you ever had surgery? Y	Yes	No
Have you ever had a serious injury?	Yes	No
Have you ever had a head injury?	Yes	No
Have you ever had x-rays?	Yes	No
Have you ever had a broken bone?	Yes	No
Have you ever had a sprain/strain/dislocation?	Yes	No
Have you ever had a "stinger/burner?"	Yes	No
Have you ever passed out?	Yes	No
Have you ever had chest pain?	Yes	No
Have you ever had high blood pressure?	Yes	No
Have you ever had a seizure?	Yes	No
Have you ever had heat cramps/exhaustion/stroke?	Yes	No
Do you have any chronic diseases?	Yes	No

(asthma, diabetes, hepatitis, Marfan's syndrome, Monucleosis, sickle cell, kidney problems, frequent headaches, etc.)

Have you ever had any skin conditions?	Yes	No
Do you wear glasses, contacts, braces, appliances?	Yes	No
Do you need special pads/braces for sports?	Yes	No
Females – Do you have regular menstrual periods?	Yes	No
Has it been more than 5 years since your last tetanus shot?	Yes	No
Do you have any concerns to discuss with the provider?	Yes	No
Do you use any nutritional supplements?	Yes	No

Explain any "" answers from above:

I authorize the release to Heart of Champions Boxing of this and any information that may affect my participation in the Boxing program. I furthermore know of and accept the risks involved in participation in athletics and understand that serious injury, even death, is possible in such participation and voluntarily choose to accept such risks.

Athlete Signature: _____ Date: _____

STEP TWO Provider to complete assessment below:

CHECK IF NORMAL **EXPLANATION IF ABNORMAL**

CHECK IF NORMAL	EXPLANATION IF ABNORMAL
Neck	
Spine	
Shoulders	
Arms/hands	
Hips	
Thighs	
Knees	
Ankles	
Feet	
Neuromuscular (DTR	

Completed by Provider _____

STEP THREE Provider to complete assessment:

Ht: _____ Wt: _____ Body Mass Index: _____

Blood Pressure: _____ Pulse (resting): _____

Vision: _____ O.D. _____ O.S. _____

Eyes (incl. funduscopic)	
Ears, Nose, Throat	
Mouth and Teeth	
Neck	
Cardiovascular	
Chest and Lungs	
Abdomen	
Skin	
Genitalia – Hernia (Male)	

FORM COMPLETE: _____ NOT COMPLETE: _____

explain: _____

FULL PARTICIPATION ALLOWED:

Yes: _____ NO: _____

PARTIAL: _____

Provider Name, address and phone:

I have reviewed the above history:

PROVIDER SIGNATURE _____

MD/DO/CRNP

DATE SIGNED: _____