RETURNING ATHLETE PHYSICAL EVALUATION FORM

Name ___________________________ Sport ________________ Date __________

Have you had any injuries since your athletic screening here? Yes ☐ No ☐
If yes, explain

Do you have any symptoms or a condition that you would like to discuss with the physician before you participate in athletics? Yes ☐ No ☐ If yes, explain

Have you consulted an outside physician of dentist since your athletic screening here? Yes ☐ No ☐
If yes, explain

Do you have any problems that only bother you when you are participating in athletics? Yes ☐ No ☐
If yes, explain

Do you know of any reason you should NOT participate in any sport? Yes ☐ No ☐
If yes, explain

I certify the above information is accurate and correct and a true reflection of my present physical condition and I feel that I do not need to go thru the complete screening.

Athlete’s Signature __________________________________________

Review of recent injury/illness:

Weight ________ BP ________ Pulse ________ Date ________ Reviewed by ________

Referred to _______________ for _______________ by __________________

Recommendation:

Ok for unrestricted activity? Yes ☐ No ☐

Physician Signature __________________________________________

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