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SPORTS PHYSICAL FOR APPLICTION TO ATTEND SUNBURTS YOUTH ACADEMY AND IMMUNIZATION UPDATE REQUIRED

Note: this information is for official and medically confidential use only and will not be released to unauthorized persons.

Name of Student (Last, First, Middle)			Social Security Number		Date of Exam	
Street Address			City		State	Zip Code
Date of Birth	Sex	Age	Height (in.)	Weight (lb.)	Blood Pressure	

Food Allergies	Type of Allergic Reaction	Medication Allergies	Type of Allergic Reaction
_____		_____	
_____		_____	
_____		_____	

If History of Asthma, is inhaler Needed (If YES, aero chamber must be prescribed)

YES ☐ NO ☐ NA ☐

Current Medication	Dosage	Route
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Immunizations

Please provide a copy of student's updated immunization record. Student **MUST** have the following immunizations for admittance into the Sunburst Youth Academy

Tdap (Adacel within 10 years)
Meningococcal Group B
MMR
Seasonal Flu
MCV4 Booster
HPV

TB Test (TB must be administered after Jul 15,2020).

These immunizations must be up to date prior to student attending academy.

Name of Student (Last, First, Middle)

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Past and Current Medical History

Check Yes or No. If Yes, write year and have physician explain.

	Yes	No	Year		Yes	No	Year		Yes	No	Year
Asthma				Thyroid trouble or goiter				Gall bladder trouble or gallstones			
Shortness of Breath				Eating disorder				Jaundice or hepatitis			
Pain or pressure in chest				Recent gain or weight loss				Skin disease			
Chronic Cough				Swollen or painful joints				Tumor, growth, cyst, cancer			
Palpitation or pounding heart				Arthritis, rheumatism, or bursitis				Radiation therapy or chemotherapy			
Heart trouble				Bone, joint, deformity				Hernia			
High or low blood pressure				Loss of finger or toe				Hemorrhoids or rectal disease			
Frequent or severe headaches				Painful or "trick" shoulder or elbow				Frequent or painful urination			
Dizziness				"Trick" or lock knee				Bed wetting since age 12			
Fainting spells				Recurrent back pain or any back injury				Kidney stone or blood in urine			
Head injury				Wear a brace or back support				Diabetes Type I or II			
Sinusitis				Cramps in your legs				Loss of memory or amnesia			
Wear corrective lenses				Foot trouble				Periods of unconsciousness			
Eye surgery to correct visions				Plate, pin, or rod in any bone				Sleepwalking			
Lack of vision in either eye				Nerve injury				Frequent trouble sleeping			
Eye trouble				Paralysis (including infantile)				Psychiatric issues			
Wear a hearing aid				Epilepsy or seizure				Depression			
Hearing loss				Car, train, sea or air sickness				Suicide Attempt			
Recurrent ear infections				Frequent indigestion				Broken bones			
Severe tooth or gum trouble				Stomach, liver, or intestinal trouble				Hospitalizations			

DO NOT FILL OUT ANYTHING BELOW THIS MESSAGE. FOR PROVIDER ONLY!

Clearance

Student can fully participate at Sunburst Youth Academy without any physical restrictions:

YES ☐ **NO ☐**

If NO, Explain:

Typed or Printed Name of Physician (Must be MD, DO, PA, NP)	Signature	Date
Stamp of Examining Facility		

ENSURE THE PROVIDER STAMPS THIS SECTION

THE TB TEST AND RESULTS MAY BE RECORDED ON THIS FORM OR ON THE IMMUNIZATION RECORDS. MAKE SURE THE DATE OF THE TB TEST AND RESULTS HAVE BEEN COMPLETED IN THE PAST YEAR. TB TESTS COMPLETED MORE THAN ONE YEAR PRIOR TO THE START DATE WILL NOT BE ACCEPTED.

TB Test Result Form

Name: _____

DOB: _____ SEX: Male / Female

To be completed by the Physician:

Name of who read the exam (please print): _____

Date TB test was administered: _____

Date TB test result was read: _____

Result of Test: _____Positive _____Negative

Does Patient need a chest x-ray? _____Yes _____No

Signature (print name and title): _____ Date: _____

MD Stamp: **DON'T FORGET THE STAMP!**

Please attach form if taken within the last 12 months: