The American Academy of Family Physicians
Athletic Competition Health Screening Form

2026

ATHLETE

LAST NAME | FIRST NAME | AGE

SCHOOL ATTENDING | DATE OF BIRTH | SEX

PARENT/GUARDIAN *(To Be Completed By Parent/Guardian)*

NAME

ADDRESS

PHONE

PHYSICIAN *To Be Completed By Physician)*

NAME

ADDRESS

PHONE

Answer Yes or No Only	*Yes*	*No*
Chronic/Recurrent Illness?		
Hospitalization?		
Surgery other than tonsils?		
Injuries treated by physician?		
Current medications?		
Organs missing?		
Heat exhaustion/stroke?		
Dizziness, fainting, convulsions and/or headaches?		
Knocked out?		
Concussion?		
Wear glasses or contacts?		
Hearing defects?		
Dental appliances-bridge, braces, cap, plate?		
Cough/pain?		
Problems with blood pressure, heart or murmurs?		
Problems with liver, spleen or kidney?		
Hernia?		
Recurrent skin disease?		
Bone/joint injury?		
Sprain/dislocation?		
Injury that caused a missed practice or event?		
Allergies?		
Allergies to medications?		
Other allergies?		
Tetanus booster in last 10 years?		

Has player previously a contact sport? if so what sport?_____

THE INFORMATION PROVIDED ABOVE IS CURRENT AND TRUE TO THE BEST OF MY KNOWLEDGE

PARENT/GUARDIAN SIGNATURE DATE

***INFORMATION BELOW IS TO BE COMPLETED BY PHYSICIAN**

Vitals	*SATISFACTORY* Yes	No	*Physical Evaluation* Comments	*Recommended* Follow Up
Height				
Weight				
BP:_____				
General				
Head				
Eyes			Acuity: L R	
Ent				
Dental				
Chest				
Heart				
Abdomen				
Genitalia				
Skin				
Extremities Back/Neck				

SPORT PARTICIPATION APPROVED: ☐ *Yes* ☐ *No*

Limitations: _____

Comments: _____

PHYSICIAN SIGNATURE DATE