



NEW YORK SHARKS MEDICAL FORM

Swimmer's Name _____ Group _____ Date of Birth ___/___/___

Address _____ Home Phone _____

	Yes	No
1. Were you ever medically advised not to play any sport? Include date and reason below.		
2. Are you under physician's care now or had recent hospitalization? Describe below.		
3. Have you ever experienced loss of consciousness after exercise or after injury?		
4. Have you ever had a seizure (convulsion)		
A fracture, dislocation or other orthopedic injury?		
Any surgery?		
Any bleeding disorder?		
Loss of function of one kidney or testicle?		
5. Do you take any medication on a regular basis? Include name of medication and reason.		
6. Do you have any allergies, including drug allergies, hives, asthma, stinging insect bites.		
7. Have you had any heart problems, high blood pressure, recurring chest pains, palpitations, rapid or irregular heart beats?		
8. Do you have a history of fatigue or undue tiredness?		
9. Do you have a history of vision difficulties, wear glasses or contact lenses.		
10. Is there a history of sudden death in the family?		
11. Do you have any worries, etc.?		

Describe the details of any item checked **YES**

Doctor to Notify in case of emergency

Name: _____

Address: _____

Phone Number: __ (____) _____

I wish to participate in the New York Sharks Swim Team program.

Signature of Swimmer Date

Signature of Parent/Guardian Date

REVERSE SIDE TO BE COMPLETED BY PRIVATE PHYSICIAN

MEDICAL EVALUATION

	Normal	Abnormal	Description
Appearance, Nutrition			
Head, Neck (masses, range of motion, pain in Motion)			
Eyes (conjunctivitis)			
Ears (infection, perforation)			
Nose (obstruction) Throat			
Mouth, Teeth			
Chest and Lungs			
Cardiac (murmurs, clicks, rhythm)			
Abdomen (liver, spleen, masses)			
Back (deformity, range of motion, scoliosis)			
Extremities (joint mobility, instability, deformity, muscle weakness, atrophy, scars)			
Testes (presence, descent, masses)			
Genitalia-Hernia			
Neurological (reflexes, balance, coordination)			
Level of Maturation (Tanner Score 1-4)			

Based on this history and physical exam, the following abnormalities were found:

1. _____
2. _____
3. _____

Signature of Physician

Address

Phone Number

History of Immunizations/Inoculations

Measles (live) Date: _____

TB Mantous Date: _____

Mumps Date: _____

Tetanus* Date: _____
(must be within last 10 years)

Rubella Date: _____