

**PHYSICAL/ MEDICAL EXAMINATION FORM**  
**Olympia Area Rowing Junior Program**

**THIS FORM TO BE RETAINED IN CONFIDENTIAL FILE BY OAR STAFF FOR REFERENCE ONLY**

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Gender: \_\_\_\_\_ Grade: \_\_\_\_\_  
\_\_\_\_\_

Address Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BP: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

**Physical Examination (to be completed by licensed practitioner/physician):** Rowing is a strenuous sport and places strong demands on the cardiovascular system, back, shoulders, hips, and knees.

Please note any factors that may affect the athlete's participation or make this athlete susceptible to injury.

- |            |                              |
|------------|------------------------------|
| 1. HEENT   | 6. Skin                      |
| 2. Lungs   | 7. Spine/Back                |
| 3. Heart   | 8. Shoulders/Upper Extremity |
| 4. Abdomen | 1. Legs, Knees               |
| 5. Neuro   |                              |

ASSESSMENT: Participation:                      Full                      Limited                      May Not Participate

Limitations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_ Examiner's Signature: \_\_\_\_\_

Examiner's Phone: \_\_\_\_\_ Examiner's Name (Print): \_\_\_\_\_

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**Please circle "yes" or "no," and provide additional details where requested.**

1. Are you allergic to any medication (aspirin, sulfa, penicillin, etc)? No/Yes  
2. Do you have any other allergies (animals, insects, bees, foods, etc.)? No/Yes

If you answered yes to any of the above please describe allergic reaction and treatment:

3. May sunscreen be applied during the day? No/Yes  
4. Do you have any of the following conditions? No/Yes

(circle those that apply): ADD/ADHD/Blood Disorder/Diabetes/Hearing Problems/Headaches/Frequent Nosebleeds/Kidney or Bladder Problems/Mental Health Concerns/Eating Disorders/Vision Problems/Speech Problems

Please describe any of the condition (s) circled above:

5. Have you ever been told by a doctor that you have asthma or exercise-induced asthma? No/Yes  
Do you use an inhaler (Albuterol, etc.)? No/Yes  
List all asthma medications, and frequency of use:

6. Have you ever had epileptic seizures or been told by a doctor that you have epilepsy? No/Yes  
7. Do you have any medical conditions for which you are currently under treatment? No/Yes

8. Do you take any prescribed or over-the-counter medications on a regular basis (steroids, birth control pills, anti-inflammatory, antibiotics, dietary supplements, herbal, etc.)? No/Yes

9. Do you wear glasses or contacts during practice or competition? No/Yes

10. Have you ever had surgery for any reason: No/Yes  
List:

11. Have you ever had a shoulder injury that disabled you for a week or longer (dislocation, seperation)? No/Yes  
Right or Left? Type of injury

12. Have you ever inured your back? No/Yes  
Type of Injury: Dates:

13. Do you have back pain (neck/upper back/lower back)? No/Yes  
Circle those that apply: seldom/occasionally/frequently with vigorous exercise or heavy lifting

14. Do you have buttock or leg pain associated with low back pain? No/Yes

15. Have you had an x-ray, CT scan, MRI of your lower back? No/Yes  
Results:

16. Have you ever been treated for low back pain? No/Yes  
Please describe treatment:

17. Have you ever been told by a doctor/athletic trainer that you injured the cartilage in your knees? No/Yes  
Right or Left: Dates:

18. Do you have any other conditions of which we should be aware? No/Yes

Date of Last Medical Exam: \_\_\_\_\_ By Dr. \_\_\_\_\_

Date of last Tetanus shot: \_\_\_\_\_

**The questions on this form have been answered completely and truthfully to the best of my knowledge.**

(signature of athlete) \_\_\_\_\_

(type or print athlete name) \_\_\_\_\_ (date) \_\_\_\_\_

(signature of parent) \_\_\_\_\_

(type or print parent name) \_\_\_\_\_ (date) \_\_\_\_\_