Desert Arc
ARTS SPORTS RECREATION

Athlete Participation Form

Personal Information	
Athlete's Name:	Gender:
Address:	
Phone:	Cell:
Language:	DOB:
Parent / Caregiver (If Applicable)	
Name:	
Address:	
Phone:	Cell:
E-Mail:	
Emergency Contact	
Name:	Relationship:
Phone:	Additional Phone :
Name:	Relationship:
Phone:	Additional Phone:
Medical Info	
Physician:	Phone:
Address:	
Behavior Alerts:	
Current Medications: Dose:	
Medication Side Effects:	
Does Client Have Seizures?	Seizure Type:
Allergies:	

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Physical Examination

Patient Information			
First Name:	Middle:	Last:	
Address:			
City:	County:	State:	Zip:
DOB: / /	Sex: M_F__Marital Status: S__M__D__W__Sep. ___		
Physicians Information			
Name:	Address:		
Phone:	Fax:		
Medical Information			
Medical History: Major Physical and mental illness, accidents, deformities or operations, recent X-rays and lab work:			
Infectious Disease: Yes_____No _____ If "Yes", please describe:			
Present Medications and Response:			
Other Treating Physicians (Name, Address, and Nature of Treatment) :			
General Appearance and Mental Attitude:			
Weight: LBS		Height: ft. in.	
Hearing: R_____L _____		Sight (Glasses) : R___L _____	
Jaeger: R_____L _____		Sight (No Glasses) : R___L _____	
Blood Pressure: Sys/Dia_____Pulse Rate_____Dyspnea_____Cyanosis_____Edema _____			

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Please Indicate **POSITIVE FINDINGS** in below mentioned structures with a “P” if findings are positive/ Please describe briefly under comments and findings.

Eyes :	Ears :	Nose :	Mouth:
Throat:	Neck:	Lymph Nodes:	Lungs:
Heart:	Blood Vessels:	Breasts:	Abdomen:
Hernia:	G.U. :	Musculoskeletal:	Skin:
Nervous System:	Varicosities:	Anorectal	
Pelvic Exam (If Indicated) :		Rectal Exam (If Indicated) :	
Urinalysis: 1) Gross Exam_____2) Sugar_____3)Albumin_____4) Other _____			
Comments and Findings:			
Disability is: Stable:_____Progressive:_____Resolving: _____			
Diagnostic Impression:			
Recommendations, Remarks, and Prognosis: (Include need for further diagnostic studies, locomotor and self-care, prosthetic-orthotic devices)			

Please check ONLY RESTRICTED physical activities and work conditions.

Physical Activities		Work Conditions	
Walking:	Lifting:	Inside:	Dirty:
Jumping:	Carrying:	Outside:	Odors:
Balancing:	Pushing:	Cold:	Limited Light:
Climbing:	Pulling:	Dusty:	Vibration:
Crawling:	Handling:	Wet:	Moving Objects:
Standing:	Fingering:	Humid:	Cramped Quarries:
Turning:	Feeling:	Dry:	High Places:
Stooping:	Talking:	Mechanical:	Temp Change:
Crouching:	Hearing:	Working w/ Others:	Working Alone:
Kneeling:	Seeing	Other:	
Sitting:	Color Vision		
Reaching:	Depth Perception:		

Tuberculosis Exam	
Date: / /	Required:_____Not Required: _____
Determination:	

Sports I Would Like To Participate In:
Swimming :__Bocce Ball:__Golf:__Tennis:__Bowling:__Cheer:__Zumba:__Choir:__Art: ___
Annual Field Trips :___Pickle Ball:___Meditation: ____Basketball:____Tai-Chi: ___ Ball Exercises :____Guided Meditation:____

Signature:_____ **Date of Exam:** _____