2024-2025



SPORTS PHYSICAL EXAMINATION FORM

PART 1 (TO BE COMPLETED BY A PARENT OR LEGAL GUARDIAN)								
LAST NAME		FIRST NAME					GRADE	
NAME OF THE OWN OWN OF THE OWN					NIN ANALYS			
BIRTHDATE FA	LL SPORT	WINTER SPORT		SP	RING SPORT	STUD	ENT ID NUMBER	
PART 1 HEALTH HISTORY (Must be Completed by Parent/Guardian Prior to the Examination)								
Yes No Has this student had: Yes No								
1. □ □ Chronic or recurrent					Seizures or seizure disord	lore?		
					Severe or repeated instances of muscle cramps?			
3					Injuries requiring medical care or treatment?			
4. □ □ Nervous, psychiatric					Neck or back pain or injury?			
5. Loss or nonfunctioning of organs			21. □ 22. □		Knee pain or injury?			
(eye, kidney, liver, to	(eye, kidney, liver, testicle) or glands?				Shoulder or elbow pain or injury?			
	☐ ☐ Allergies (medicines, insect bites, food)?				Ankle pain or injury?			
	•				Other joint pain or injury?			
	during or after exercise?				Broken bones (fractures)? Does this student presently:			
					Wear eyeglasses or contact lenses?			
	_				Wear dental bridges, braces or plates?			
	_				Take any medications? (List below):			
12. ☐ ☐ A hit or blow to the head causing confusion, prolonged			28. □	_	Further history:			
	headache or memory problems?				Birth defects (corrected or not)?			
					Death of a parent or grandparent less than 40			
your arms or legs aft			years of age due to medical cause or condition?					
14. ☐ ☐ History of migraine 15. ☐ ☐ Heat exhaustion, hea	31. 🗖		Parent or grandparent requiring treatment for					
managing or respond	32. □	_	heart condition less than 50 years of age?					
16. ☐ ☐ Racing heartbeat, skipped or irregular heartbeats, or				Ш	Been seen by a physician			
16. Racing heartbeat, skipped or irregular heartbeats, or urgent basis in the last 12-months?							S?	
Date of last known tetanus (lockjaw) shot: Date of last complete physical examination:								
Explain all "YES" answers. Describe any other fact that should be disclosed prior to the examination (use reverse of form if needed):								
in the state of th								
PARENT/GUARDIAN'S AUTHORIZATION: I authorize the health care provider to perform a Sports Physical Evaluation on the student. The								
information set forth above is complete and accurate. I presently know of no reason why the student cannot fully and safely participate in the listed								
sports. For Sports Physical Evaluations that may be performed by District volunteers, I understand the evaluation is a screening evaluation only, and								
that I must address all health care concerns with the Student's personal physician or health care provider. PRINT NAME OF PARENT OR GUARDIAN SIGNATURE OF PARENT OR GUARDIAN								
TREAT PARENT OR QUARDIAN SIGNATURE OF FARENT OR QUARDIAN								
ADDRESS			WORK PHONE HOME PHONE			- 11	DATE	
REGULAR PHYSICIAN'S NAME			OFFICE PHONE PROVIDER CLIN			R ORGA	NIZATION	
PART 2 – MEDICAL EVALUATION (TO BE COMPLETED BY THE EXAMINING HEALTH CARE PROVIDER)								
This Evaluation Can Only be Performed by Medical Doctors (MDs), Doctors of Osteopathy (DOs), Physician's Assistants (P.A.s), and Nurse Practitioners (N.P.s)								
	NORMAL	ABNOR	MAL (Desci	ribe)	(May be con	tained	on Provider's Form)	
Eyes/Ears/Nose/Throat	TOTALLE	71271011	IVII IE (Beser	1100)	Height:		Weight:	
Heart, lungs, pulmonary function	1				Pulse:		After Ex:	
Abdomen, genital/hernia (males)					BP:		THEFEA.	
Skin and Musculoskeletal:				ecomn	nendation:			
a. Neck/Spine/Shoulders/Back					☐ Unlimite			
b. Arms/Hands/Fingers								
	☐ Limited participation/specific sports, events or activities							
c. Hips/Thighs/Knees/Legs d. Feet/Ankles				☐ Clearance withheld pending				
				further testing/evaluation				
Neurologic Screening Exam (NSE)/			□ No athletic participatio					
Concussion Screening Evaluation								
(only if needed based on above info.) One of the above MUST be check PHYSICIAN STAMP								
Comments:								
PRINT NAME OF PHYSICIAN	PH	YSICIAN'S SIGNATU	JRE			ATE		