Athletic Physical Examination Form

Name: _____ Birth Date: _____ Gender: M F

Grade: _____ School: _____ Sport: _____

Address: _____ Home Phone: _____

Father's Name: _____ Daytime Phone: _____

Mother's Name: _____ Daytime Phone: _____

Additional Emergency Contact Person (in the event neither parent can be reached):

Name: _____ Relation: _____ Daytime Phone: _____

Medical History

	Yes	No		Yes	No
Any significant past injuries			Hospitalizations or surgeries		
Allergies, asthma, or wheezing			Seizures		
Contact lenses or glasses			Head injuries or concussions		
Currently on medication/medications			Bone or joint injuries		
Chronic illness			Current on all vaccinations		
Allergies			Other:		

Comments:

_____

_____

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Physical Exam

	Result	Comments		Result	Comments
Ears			Neurological		
Nose			Genito-urinary		
Throat			Gastrointestinal		

Eyes			Spinal		
Skin			Mental Health		
Dental/Mouth			Cardiovascular		
Lungs			Musculoskeletal		

Final Diagnosis:

_____

_____

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_____

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I approve this student's participation in an interscholastic sport for one year. Yes No

Physician/PNP Name:

_____ Physician/PNP

Signature: _____ Date: _____