Athletic Physical Form

Name: _____ Age: _____ Grade: _____

Date: _____ Sport(s): _____

Address: _____ Phone: _____

Guardian 1: _____ Phone: _____

Guardian 2: _____ Phone: _____

Emergency Contact: _____ Phone: _____

By signing this the parent consents to the student's Physical Exam given:

Parent Name: _____ Date: _____

Parent Signature: _____

Medical History

Significant Previous Injuries: ☐ No ☐ Yes: _____

Hospitalizations or Surgeries: ☐ No ☐ Yes: _____

Bone or Joint Injuries: ☐ No ☐ Yes: _____

Current Medications: ☐ No ☐ Yes: _____

Past Medications: ☐ No ☐ Yes: _____

Chronic Illness: ☐ No ☐ Yes: _____

Allergies: ☐ No ☐ Yes: _____

Vaccinations are Current: ☐ No ☐ Yes: _____

Seizures: ☐ No ☐ Yes Glasses or Contact Lenses: ☐ No ☐ Yes

Asthma: ☐ No ☐ Yes Fainting/Dizzy Spells: ☐ No ☐ Yes

Physical Exam

Height: _____ Weight: _____ Blood Pressure: _____

Feature	Result	Comments
General		
Eyes		
Nose		
Dental/Mouth		
Throat		
Ears		
Skin		
Cardiovascular		
Musculoskeletal		
Neurological		
Genitourinary		
Gastrointestinal		
Spinal		
Nutritional Status		
Mental Health		

Additional Comments: _____

_____

_____

I approve this student's participation in interscholastic sports for one (1) year. ☐ Yes ☐ No

Physician: _____ Signature: _____ Date: _____

PNP: _____ Signature: _____ Date: _____