

**SPORTS PHYSICAL**

**I. To Be Completed By Parent**

Player's Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Please fill out the following. If no problem, indicate "none." Do not leave blanks.

Glasses: Yes \_\_\_\_\_ No \_\_\_\_\_ Teeth: Fragile Dental Work: Yes \_\_\_\_\_ No \_\_\_\_\_

Medical Conditions (Diabetes, Seizures, Asthma, Lyme Disease, etc.) \_\_\_\_\_  
\_\_\_\_\_

Previous Surgery \_\_\_\_\_

Previous Fractures \_\_\_\_\_

Allergies \_\_\_\_\_

Medications \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

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**II. To Be Completed By Physician**

Physician findings:    0 - no defect  
                                  1 - slight defect, not requiring immediate attention  
                                  2 - defect requiring immediate attention  
                                  C - corrected  
                                  TR - under treatment

Height \_\_\_\_\_ Weight \_\_\_\_\_

Heart Rate \_\_\_\_\_ Blood Pressure \_\_\_\_\_ / \_\_\_\_\_ Eyes \_\_\_\_\_

Ears \_\_\_\_\_ Thyroid \_\_\_\_\_ Heart & Lungs \_\_\_\_\_

Skin \_\_\_\_\_ Hernia \_\_\_\_\_ Nervous System \_\_\_\_\_

Spine/Scoliosis \_\_\_\_\_

Comments: (Use reverse side for additional comments) \_\_\_\_\_  
\_\_\_\_\_

Is this person physically able to participate in the school sports program?    Yes \_\_\_\_\_ No \_\_\_\_\_

Is further examination required?    Yes \_\_\_\_\_ No \_\_\_\_\_

Date of Exam \_\_\_\_\_ Physician's Signature \_\_\_\_\_