

## Athletic Physical Form

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_  
 Date: \_\_\_\_\_ Sport(s): \_\_\_\_\_  
 Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Guardian 1: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Guardian 2: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Phone No.: \_\_\_\_\_

### Medical History

Significant Previous Injuries:	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes:	
Hospitalizations or Surgeries:	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes:	
Bone or Joint Injuries:	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes:	
Current Medications:	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes:	
Past Medications:	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes:	
Chronic Illness:	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes:	
Allergies:	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes:	
Vaccinations are Current:	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No:	
Seizures:	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	Glasses or Contact Lenses: <input type="checkbox"/> No <input type="checkbox"/> Yes
Asthma:	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	Fainting/Dizzy Spells: <input type="checkbox"/> No <input type="checkbox"/> 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: \_\_\_\_\_