

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:	<input type="text"/>
Hospitalizations or Surgeries:	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes:	<input type="text"/>
Bone or Joint Injuries:	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes:	<input type="text"/>
Current Medications:	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes:	<input type="text"/>
Past Medications:	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes:	<input type="text"/>
Chronic Illness:	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes:	<input type="text"/>
Allergies:	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes:	<input type="text"/>
Vaccinations are Current:	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No:	<input type="text"/>
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: _____