PHYSICAL **Must not expire during current activity season**

To be performed and completed by a Physician, Advanced Nurse Practitioner or Physician's Assistant.

ATHLETE'S NAME (print): ______________________________

	Yes	No
1. Has anyone in your family died of heart problems or a sudden death before age 50?	◯	◯
2. Have you ever passed out or had chest pain while or after exercising?	◯	◯
3. Do you have trouble breathing or do you cough during or after activity?	◯	◯
5. Have you ever had an illness/injury that required hospitalization, surgery or repeated doctor visits?	◯	◯

Explain

Age ______ Height ______ Weight ______ Blood Pressure ______

Vision R/20 ______ Vision L/20 ______ Correction: ☐ Yes ☐ No

INSTRUCTIONS: (O) if normal (X) if abnormal *Please explain X by indicating # and using comments*

1. ___ Eyes/ears/nose/throat
2. ___ PERRLA
3. ___ Respiratory
4. ___ Cardiovascular
5. ___ Liver/spleen/abdomen
6. ___ Genitalia, tanner stage
7. ___ Neurological
8. ___ Skin
9. ___ Head/neck
10. ___ Shoulders/arms
11. ___ Knee/hip
12. ___ Back
13. ___ Ankles
14. ___ Other musculoskeletal
15. ___ Hearing acuity
16. ___ Lab-UA, HGB/HCT

Comments

I certify that I have on this date examined this pupil and find this pupil physically able to compete in all supervised activities NOT circled:

BASEBALL BASKETBALL CHEERLEADING XC RUNNING XC SKIING FOOTBALL HOCKEY MARCHING BAND

RIFLE TEAM SOCCER SWIMMING/DIVING TRACK VOLLEYBALL WRESTLING WEIGHT LIFTING SOFTBALL

Examining Physician's Signature ______________ Printed Name ______________ Date ______________

THIS SECTION TO BE COMPLETED BY THE ACTIVITIES OFFICE

Physical Date	Practice Eligibility Date	Current Credit Load	S2 GPA	Q1 GPA	S1 GPA	Q3 GPA	Fee	Cash/ Check	HSGQE PASSED?

REV 05/18/09 MM