ATHLETIC/ACTIVITY PHYSICAL

ATHLETE'S NAME (print): ______________________ DOB: __________ ☐ Male ☐ Female

School: ______________________ Grade: ________ ID #: ______________

Parent/Guardian Name (print): ______________________

Parent/Guardian Signature: ______________________ Date: ____________

PHYSICAL

** Must not expire during current activity's season.**

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

	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?...	____	____
4. 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: Y	N

INSTRUCTIONS: (O) if normal (X) if abnormal

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. ____ Knees/Hips
12. ____ Back
13. ____ Ankles
14. ____ Other Musculoskeletal
15. ____ Hearing acuity
16. ____ Lab-UA, HGB/HCT

Please explain X by indicating #

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

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

Examining Physician's Signature: ______________ Printed name: ______________ Date: __________

In accordance with ASAA regulations, all physical exams must be completed by an MD, DO, PA or ANP only.