



**Athletic/Activity Physical Examination Form**

Mat-Su Borough School District  
501 N. Gulkana  
Palmer, AK 99645  
P: (907) 746-9200 || F: (907) 761-4076

Student's Name (Print): \_\_\_\_\_ Date of Birth: \_\_\_\_\_  Male  
 Female  
School: \_\_\_\_\_ Grade: \_\_\_\_\_ ID #: \_\_\_\_\_  
Parent/Guardian Name (Print): \_\_\_\_\_  
Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

This form must be submitted to the individual school where your student will be participating in the sport or activity.

**PHYSICAL EXAMINATION**

**\*\* Must not expire during current athletic/activity season.\*\***

*In accordance with ASAA regulations and School Board Policy (BP 5141.3), all physical exams must be performed and completed by a **Medical Doctor, Doctor of Osteopathy, Physician's Assistant, Nurse Practitioner, or Chiropractor.***

	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 during or after exercising?.....	___	___
3. Do you have trouble breathing or do you cough during or after an activity?.....	___	___
4. Have you ever had an illness or 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

- 1. \_\_\_ Eyes/Ears/Nose/Throat    5. \_\_\_ Liver/Spleen/Abdomen    9. \_\_\_ Head/Neck    13. \_\_\_ Ankles
- 2. \_\_\_ PERRLA    6. \_\_\_ Genitalia, Tanner Stage    10. \_\_\_ Shoulders/Arms    14. \_\_\_ Other Musculoskeletal
- 3. \_\_\_ Respiratory    7. \_\_\_ Neurological    11. \_\_\_ Knees/Hips    15. \_\_\_ Hearing acuity
- 4. \_\_\_ Cardiovascular    8. \_\_\_ Skin    12. \_\_\_ Back    16. \_\_\_ Lab-UA, HGB/HCT

Please explain X by indicating #

Comments: \_\_\_\_\_

I certify that I have examined this student and find him/her 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

Printed Name of Physician: \_\_\_\_\_

Signature of Physician (MD, DO, PA, NP, DC): \_\_\_\_\_

Date: \_\_\_\_\_