SPORTS PHYSICAL SCHOOL FORM

I grant permission to release the information below to School Personnel.

SIGNATURE OF PARENT/GUARDIAN: _____

NAME: _____ Date of Birth: _____ Student ID: _____

Sports: _____ School: _____ Grade: _____

Emergency Contact: _____ Cell Phone: _____ Home Phone: _____

ALLERGIES: _____ MEDICATIONS: _____

Date of Exam: _____ Height: _____ Weight: _____ BMI: _____ Pulse: _____ BP: ____/____

Hearing: ☐ Passed Right/Left ≤25dcbls (all frequencies) Vision: R 20/___ L 20/___ Both 20/___ Corrected: Y/N
☐ Failed_____ ☐ Not Done U/A: ☐ Normal _____

Required Immunizations: Measles, Mumps Rubella; Hepatitis B, Polio, and Tetanus and Pertussis.
☐ Received Varicella Vaccine/ or Varicella illness after 1 yr. of Age Date of Last Tdap: _____

☐ Up to date (See Attached Vaccine Documentation) ☐ Not up to Date, Vaccines Needed: _____

MEDICAL:	NORMAL	ABNORMAL FINDINGS
General Appearance		
Head eyes/ears/nose/throat		
Neck		
Respiratory		
Heart		
Pulses		
Abdomen		
Skin		
Neuro		
Lymph Nodes		
Genitourinary (males only)		

MUSCULOSKELETAL:	NORMAL	ABNORMAL FINDINGS
Back (including scoliosis screen)		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		

Assessment/Plan: _____ OFFICE STAMP:

☐ Cleared for all sports without restrictions

☐ Not Cleared for ☐All sports ☐Certain sports_____

Reason:_____

☐ Deferred requires further evaluation (See Recommendations Below):

☐ Cleared with restrictions (See Recommendations Below):

Recommendations: _____

Name of Physician (print)_____ Address: _____ Phone: _____

Signature of Physician:_____, M.D., D.O., or N.P. Date:_____

Based on recommendations developed by the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopedic Society for Sports Medicine and American Osteopathic Academy for Sports Medicine. Rev. Dec 2010.