

# 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 <25dcbis (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, Tetanus, Pertussis, and Varicella/illness.

Up to date (See Attached Vaccine Documentation)       Not up to date, Vaccines Needed: \_\_\_\_\_  
 Baseline Concussion Assessment Complete (Recommended)

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: \_\_\_\_\_