Athletic Physical Form

Name: _____ Age: _____ Grade: _____
Date: _____ Sport(s): _____
Address: _____ Home Phone: _____
Guardian 1: _____ Work Phone: _____
Guardian 2: _____ Work Phone: _____
Emergency Contact: _____ Phone No.: _____

Medical History

Significant Previous Injuries:		No		Yes:					
Hospitalizations or Surgeries:		No		Yes:					
Bone or Joint Injuries:		No		Yes					
Current Medications:		No		Yes:					
Past Medications:		No		Yes:					
Chronic Illness:		No		Yes:					
Allergies:		No		Yes:					
Vaccinations are Current:		Yes		No:					
Seizures:		No		Yes	Glasses or Contact Lenses:		No		Yes
Asthma:		No		Yes	Fainting/Dizzy Spells:		No		Yes

Physical Exam

Height: _____ Weight: _____ Blood Pressure: _____

Feature	Result	Comments
General		
Eyes		
Nose		
Dental/Mouth		
Throat		
Ears		
Skin		
Cardiovascular		
Musculoskeletal		
Neurological		
Genitourinary		
Gastrointestinal		
Spinal		
Nutritional Status		
Mental Health		

Additional Comments: _____

I approve this student's participation in interscholastic sports for one (1) year. ☐ Yes ☐ No

Physician: _____ Signature: _____ Date: _____

PNP: _____ Signature: _____ Date _____