



Athletic/Activity Physical Examination Form

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 that your student will be participating in athletic/activity program.

PHYSICAL EXAMINATION

**** Must not expire during current athletic/activity season.****
In accordance with ASAA regulations, all physical exams must 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 during or after exercising?..... | ___ | ___ |
| 3. Do you have trouble breathing or do you cough during or after 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): _____ Date: _____