

Sport Physical Form

Sport: _____ For School Year: _____

Student Name: _____ Physical Date: _____
Last First MI

Sex: Male Female Weight: _____ Height: _____ Pulse: _____ Blood Pressure: _____

Legend: ✓ = Normal X = Abnormal NE = Not examined

General Body Build: _____ Skin: _____

Eye: _____ Ear: _____ Nose: _____ Throat: _____ Teeth: _____ Neck: _____

Lungs: _____ Heart: _____ Chest: _____ Liver: _____ Spleen: _____ Spine: _____

Abdominal Masses/Hernia: _____

Joint Function:

Neck: _____ Shoulders: _____ Elbows: _____ Wrists: _____ Hands: _____ Hips: _____

Knees: _____ Ankles: _____ Feet: _____

*Neurological: _____ Genitalia (male only): _____

* Important if medical history is positive for concussions, seizures, loss of consciousness or other neurological findings.

Concussion	When	
Fractures	When, Where	
Sprains	When, Where	
Chronic inflammation	Where	
Heart murmur	When	
High blood pressure	When, Reading	

Allergies: _____ Medications: _____

Special Instructions or Limitations: _____

I certify that I have examined this student and he or she may compete in supervised school athletic activities.

Date of examination: _____ Physician Name: _____

Physician phone #: _____ Physician Signature: _____

NOTE: Return completed Sport Physical Form to CLS office with completed registration form.