

NAME: _____ DATE _____

Sports Physical Examination

This portion is to be completed by a **Medical Professional** ~ not more than **six** months prior to entering school.

Age _____ Height _____ Weight _____ PULSE: Resting _____
 Exercise _____
 BP _____ / _____ Resp. _____ Vision: L 20/ _____ R 20/ _____

	N	Abn			N	Abn
Skin				Dental		
Eyes				Ortho		
Mouth				Spine		
Nose				Upper Extrem.		
Neck				Lower Extrem.		
Chest				Strength & ROM		
Breast				Neurologic		
Pulses				Psychiatric		
Lungs						
Abdomen						
Liver						
Spleen						
Genitalia						

Tanner Stage: _____ Notes: _____

Scoliosis: _____

ACTIVITY LEVEL SUMMARY

- | | | |
|-----------------------------|--------------------------|---------------------|
| 1. Full Participation | <input type="checkbox"/> | Type of Sport _____ |
| 2. Limited Participation | <input type="checkbox"/> | |
| 3. Needs Further Evaluation | <input type="checkbox"/> | Type of Sport _____ |
| 4. No Participation | <input type="checkbox"/> | |

Classification of Sports

Strenuous			Moderately Strenuous	Nonstrenuous
Contact	Limited Contact	No contact		
Football	Basketball	Crew	Badminton	Archery
Ice Hockey	Field Hockey	Cross Country	Baseball (limited contact)	Bowling
Lacrosse (boys)	Lacrosse (girls)	Fencing	Golf	Riflery
Rugby	Soccer	Swimming	Table Tennis	
Wrestling	Volleyball	Tennis	Curling	
	Gymnastics	Track and Field		
	Skiing			
	Water Polo			

School Nurse Review:

-Request for further evaluation sent

-Results of further evaluation received

Medical Professional Signature & Date:
