

# SPORTS PHYSICAL EXAMINATION

Required within 24 months of Sports Participation

(To be completed by MD, APRN, or PA)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ has had a history and physical exam on \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Student's Name Birth Date

	Normal	Abnormal Findings
Appearance		
Skin		
HEENT		
Respiratory		
Cardiovascular	Arrhythmia Murmur	
Abdomen		
Spine		
Neurological		
Genitalia (hernia)		
Physical Maturity (Tanner Stage)	1 2 3 4 5	

HEIGHT _____	WEIGHT _____
BLOOD PRESSURE _____	
HCT/HGB _____	
PULSE _____	
URINALYSIS _____	protein _____ blood _____ glucose _____
VISUAL ACUITY:	right _____ left _____
Corrected to	right _____ left _____
HEARING _____	
LAST TETANUS BOOSTER _____	
LAST MEASLES (MMR) BOOSTER _____	
OTHER IMMUNIZATIONS _____	
BODY FAT (optional) _____	
CHOLESTEROL (optional) _____	

SUMMARY: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## ORTHOPEDIC EXAM MUSCULO-SKELETAL EVALUATION to include range of motion, strength, flexibility

	Normal	Abnormal Findings
Neck		
Spine		
Shoulders		
Arms / Hands		
Hips		
Thighs		
Knees		
Ankles		
Feet		

### RECOMMENDATIONS

Weight Loss / Gain _____	Medications _____
Strengthening _____	Special Equipment _____
Stretching _____	Bracing / Taping _____
Conditioning (Endurance) _____	

I certify that on this date, on the basis of the examination requested by the school authorities and the student's medical history as furnished to me, I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities except:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 Provider Signature Date Telephone Printed Name or Stamp