SCHOOL AND SPORTS PHYSICAL EXAMINATION

Date of Exam:________________

CHILD"S NAME:___________________________________ DOB: ___________________

IMMUNIZATIONS: SEE OTHER SIDE *or attach Immunization Record*

VISION: Without glasses R:20/___ L:20/___ With glasses R:20/___ L:20/___ Lead:_______

HEARING: R.__________ L.__________ Lab: Hbg__________ U/A_____ PPD_____ Results__________

PHYSICAL EXAMINATION: Height:__________ Weight:__________ BP:__________

Head	Eyes
ENT	Mouth & Teeth
Neck & Soft Tissue	Chest
Heart	Lungs
Abdomen	Genitalia
Hernias	Neurological
Skin	Back & Spine
Joints	Maturity Index

Based on this history and physical exam, the following abnormalities were found and may need treatment:

1.____

2.____

There were no history of physical findings on this exam which would prohibit this student from participating in:

___Preschool ___Kindergarten ___Other____

SPORTS PARTICIPATION RECOMMENDATIONS

1. ___ There were no history of physical findings on this exam which would prohibit this student from participating in competitive athletics.
2. ___This student should have the following health problems evaluated or treated prior to participating in competitive athletics: ____
3. ___This student has health problems which would prohibit him/ber from participating in competitive athletics.

____

Condition

______________________________________ ________________

Provider Signature **Date**

____

Provider Name - Print

Clinic/Office Name & Address:____

revised 7/10/13

Please COMPLETE OTHER SIDE *(or attach immunization record)*

DATES of IMMUNIZATION:

Immunization	Primary			Booster		Allergies
DPT/DTAP						
DT						
IPV (Polio)						
MMR						
HIS						
HEP B						
VARICELLA						
OTHER						

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