



CIF SPORTS EXAMINATION REPORT

(Please print or type)

Student's Name _____ Grade _____
Last First Middle Initial

Birthdate _____ Age _____ Circle: Male / Female

Address _____
Street Apt. No. Zip

Home phone _____ Cell phone _____

Mother's work phone _____ Father's work phone _____

TO BE COMPLETED BY STUDENT'S LICENSED PHYSICIAN AND SURGEON:

Blood pressure (MUST be recorded) _____ S/ _____ D Weight _____ Height _____

Pulse: resting _____ after one minute of exercise _____ after one minute of rest _____

Vision: R _____ L _____ with or without correction (circle one) Hearing _____

Please indicate findings for all areas below, indicate N if normal and Ab if abnormal. Please describe in detail all abnormal findings.

- Head _____ Nose _____ Chest _____ Legs _____
Neck _____ Mouth _____ Heart _____ Abdomen _____
Eyes _____ Teeth _____ Lung _____ Hernia _____
Ears _____ Throat _____ Arms _____ Joints _____
Spine _____

Comments on any abnormal findings:

1. Is there any history of acute or chronic illness? Yes ___ No ___
If yes, explain in detail _____

2. Is there any history of epilepsy/seizure disorder or unconsciousness? Yes ___ No ___
If yes, explain in detail _____

3. Is there a history of hospitalization/surgery? Yes ___ No ___
If yes, explain in detail (when and reason) _____

4. Is student taking any medication on a regular basis? Yes ___ No ___
If yes, what medication and reason for taking it: _____

5. Student may participate in **ALL** athletic activities YES NO

6. If **NO** is checked above, please indicate all activities in which student may participate:

Badminton _____	Football _____	Soccer _____	Track/Field _____
Baseball _____	Golf _____	Softball _____	Volleyball _____
Basketball _____	Gymnastics _____	Swimming _____	Water Polo _____
Field Hockey _____	Pep Squad _____	Tennis _____	Weight Lifting _____
		ROTC _____	Wrestling _____

Other (please specify) _____

7. List any restrictions and/or recommendations: _____

8. Is an adapted physical education program indicated? Yes ___ No ___

If yes, state reason and duration _____

9. IMMUNIZATIONS MUST BE UP TO DATE TO PARTICPATE IN SPORT ACTIVITES.

List dates of all immunizations given:

Td _____ MMR _____ Hepatitis B _____ Varicella _____ OPV/PV _____

Other _____ Mantoux(PPD) _____ Date Read: _____ Result: _____

LICENSED PHYSICIAN STATEMENT

I have examined _____ on _____
Student Name Date of exam

and find that he/she may participate in the physical education programs I have indicated.

Signature of licensed physician (PA must have physician's co-signature or name stamp of physician. NP must have license number.) Today's date

Please PRINT name of licensed physician and surgeon) Phone

Address/Facility stamp (physical will not be accepted without stamp)

PLEASE RETURN THIS FORM TO THE NURSE AT _____ SCHOOL

I have reviewed the **PHYSICAL EXAMINATION REPORT**.

Signature of school nurse Date

Comments:

