

PHYSICAL FORM ~ Sports Qualifying Screening Evaluation

Name: _____

DOB: ____/____/____

Primary Ph. #: _____

E-MAIL: _____

GRADE IN FALL _____

*****I do not know of any existing conditions or health reason that would preclude participation in sports.**

Parent/Legal Guardian Signature:

_____/_____/_____
Date

Medical Exam

DATE OF ENCOUNTER ____/____/____

	NORMAL	ABNORMAL	COMMENTS		NORMAL	ABNORMAL	COMMENTS
Eyes	_____	_____	_____	Neck	_____	_____	_____
Ears	_____	_____	_____	Spine	_____	_____	_____
Mouth	_____	_____	_____	Shoulder	_____	_____	_____
Throat	_____	_____	_____	Elbow	_____	_____	_____
Dental	_____	_____	_____	Hands/Arms	_____	_____	_____
Thyroid	_____	_____	_____	Hips	_____	_____	_____
Cardiovascular	_____	_____	_____	Thighs	_____	_____	_____
Chest & Lungs	_____	_____	_____	Knees	_____	_____	_____
Abdomen	_____	_____	_____	Ankles	_____	_____	_____
Genitalia-Hernia	_____	_____	_____	Feet	_____	_____	_____

PHYSICAL MATURITY: **1** **2** **3** **4** **5**

HT: _____ WT: _____ BP: _____ Pulse: _____

I herewith certify that (*child's name*) _____ has been evaluated in the above areas and there are no observable conditions which would contraindicate his /her participation in the following activities:

CLEARED for:

NOT CLEARED for:

Collision Sports:

Contact Sports:

Non-Contact Sports:

Physician Signature

Physician Name PRINTED

_____/_____/_____
Date

_____/_____/_____
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