SPORTS PHYSICAL FORM

Name: _____ **Gender: M F** **Date of Birth:** ____ / ____ / _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **Phone:** _____

Medical History / Allergies: _____

_____

_____

_____

Height: _____ **Weight:** _____ **Pulse:** _____ **Blood Pressure:** _____

	Normal	Abnormal Findings	Initials
01. Eyes			
02. Ears, Nose, Throat			
03. Mouth & Teeth			
04. Neck			
05. Cardiovascular			
06. Chest & Lungs			
07. Abdomen			
08. Skin			
09. Musculoskeletal: ROM, strength, etc			
a. neck			
b. spine			
c. shoulders			
d. arms/hands			
e. hips			
f. knees			
g. ankles			
h. feet			
10. Neuromuscular			

PHYSICIAN'S STAMP:

I certify that I have examined this athlete and found him/her medically qualified to participate in sports activities. I also certify that I am a licensed physician.

Physician's Signature _____ Date _____

Participation Recommendations: _____

_____

_____