
Sports Physical Explanation/Evaluation

NEW FORM – This is the form to be used for sports participation for 2009-2010

All physical forms **MUST** be returned to school, **PRIOR TO THE FIRST PRACTICE** of the first sport in which your child intends to participate. There can be **NO EXCEPTIONS**. Your current form is valid until its expiration date. This is the only form that will be accepted this year.

NOTE: If your child needs an inhaler for asthma or any other condition, please fill out and return the appropriate medical form, which must also be filled out and signed by your physician. Sports physicals are valid for one year from the date of the examination. Thank you in advance for your understanding and cooperation.

See Evaluation Form Attached



FRIENDS SCHOOL MULLICA HILL
SPORTS PHYSICAL FORM
2009-2010

Must be completed and signed by an Authorized Medical Examiner and turned in to the School Nurse prior to participation in sports for the 2008-2009 school year.

Date of Examination: _____

Student's Name: _____

Age: _____

Grade: _____

Enrolled in _____ School Sport(s) _____

Height: _____ Weight: _____ Pulse: _____ BP: ____/____ (____/____, ____/____)

Vision R 20/____ L 20/____ Corrected YES NO (circle one) Pupils: Equal _____ Unequal _____

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
Eyes/Ears/Nose/Throat		
Hearing		
Lymph Nodes		
Cardiovascular		
Cardiopulmonary		
Lungs		
Abdomen		
Genitourinary (males only)		
Neurological		
Skin		
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		

CLEARED **CLEARED**, with recommendation(s) for further evaluation or treatment for: _____

NOT CLEARED for the following types of sports (please check those that apply):

- COLLISION CONTACT NON-CONTACT STRENUOUS MODERATELY STRENUOUS NON-STRENUOUS

Due to _____

Recommendation(s) / Referral(s) _____

Authorized Medical Examiner's Name (print/type) _____ License # _____

Address _____ Phone (____) _____

Authorized Medical Examiner's Signature _____ MD, DO, PAC, CRNP, OR SNP (circle one)

Date ____/____/____