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## 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 \_\_\_\_/\_\_\_\_/\_\_\_\_