



Student's Name \_\_\_\_\_ D.O.B. \_\_\_\_\_  Male  Female

PHYSICIAN'S EXAM

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Spinal Curvature \_\_\_\_\_

Last Tetanus toxoid booster was on \_\_\_\_\_

Physical Evaluation

\_\_\_\_\_ I find this student physically qualified to participate in ALL supervised sports.

\_\_\_\_\_ This student should have the following problems evaluated prior to participation in ANY competitive athletics:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ This student has health problems, which would prohibit him/her from participating in specific competitive athletics.

RESTRICTIONS CIRCLED BELOW:

Badminton	Fencing	Ice Hockey	Soccer	Volleyball
Baseball	Field Hockey	Indoor Track	Softball	Water Polo
Basketball	Football	Lacrosse	Swimming	Wrestling
Cheer Lading	Golf	Rugby	Tennis	Other _____
Cross Country	Gymnastics	Skiing	Track	_____

In addition to reviewing the health history and immunization records, this certifies that I have performed a complete Physical Exam including evaluation of the musculo-skeletal system.

**IN ORDER FOR THIS EXAM TO BE ACCEPTABLE FOR A SPORTS SEASON IT MUST HAVE BEEN PERFORMED WITHIN TWELVE MONTHS PRIOR TO THE STARTING DATE OF TRYOUTS FOR THE SPORT.**

\_\_\_\_\_  
Signature of Physician      Date of Exam      Telephone      Physician (Stamp)

Please return to the Public Health Nurse in your child's school by the first date of tryouts for that sport.

Form reviewed by: \_\_\_\_\_  
PHN (Initials)