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 OFFICE USE ONLY!