
# PHYSICAL EXAMINATION FORM

PARTICIPANTS NAME: _____

AGE: _____ DATE OF BIRTH: _____

**TO PHYSICIAN:** Your careful examination and written recommendation will encourage personal fitness and safe participation in strenuous sports activities.

PLEASE COMPLETE THE FOLLOWING PHYSICAL EVALUATION AND REVIEW MEDICAL HISTORY WITH PARTICIPANT.

| | NORMAL | ABNORMAL |
|---|---|---|
| **WEIGHT:** | _____ | _____ |
| **EYES, EARS, NOSE, THROAT:** | _____ | _____ |
| **BLOOD PRESSURE:** | _____ | _____ |
| **HEART:** | _____ | _____ |
| **LUNGS:** | _____ | _____ |
| **ABDOMEN:** | _____ | _____ |
| **HERNIA:** | _____ | _____ |
| **EXTREMETIES:** | _____ | _____ |
| **SPINE (POSTURE):** | _____ | _____ |

**MEDICAL HISTORY:**

**Check any of the following illnesses or symptoms that have occurred to the participant in the past or present time.**

_____ ASTHMA _____ FAINTING _____ DIABETES

_____ HEADACHES _____ HEART TROUBLE _____ CONVULSIONS

_____ HEAD INJURIES _____ CONCUSSIONS

MEDICATION ALLERGIES: _____

PARENT SIGNATURE: _____ DATE: _____

I approve this athlete's participation in youth sport for one year. _____ Yes _____ No

SIGNATURE: _____ DATE: _____

**PHYSICIAN, NURSE PRACTITIONER, OR RN**