



CIF SPORTS EXAMINATION REPORT

(Please print or type)

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_
Last First Middle Initial

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Circle: Male / Female

Address \_\_\_\_\_
Street Apt. No. Zip

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Mother's work phone \_\_\_\_\_ Father's work phone \_\_\_\_\_

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TO BE COMPLETED BY STUDENT'S LICENSED PHYSICIAN AND SURGEON:

Blood pressure (MUST be recorded) \_\_\_\_\_ S/ \_\_\_\_\_ D Weight \_\_\_\_\_ Height \_\_\_\_\_

Pulse: resting \_\_\_\_\_ after one minute of exercise \_\_\_\_\_ after one minute of rest \_\_\_\_\_

Vision: R \_\_\_\_\_ L \_\_\_\_\_ with or without correction (circle one) Hearing \_\_\_\_\_

Please indicate findings for all areas below, indicate N if normal and Ab if abnormal. Please describe in detail all abnormal findings.

- Head \_\_\_\_\_ Nose \_\_\_\_\_ Chest \_\_\_\_\_ Legs \_\_\_\_\_
Neck \_\_\_\_\_ Mouth \_\_\_\_\_ Heart \_\_\_\_\_ Abdomen \_\_\_\_\_
Eyes \_\_\_\_\_ Teeth \_\_\_\_\_ Lung \_\_\_\_\_ Hernia \_\_\_\_\_
Ears \_\_\_\_\_ Throat \_\_\_\_\_ Arms \_\_\_\_\_ Joints \_\_\_\_\_
Spine \_\_\_\_\_

Comments on any abnormal findings:

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

1. Is there any history of acute or chronic illness? Yes \_\_\_ No \_\_\_
If yes, explain in detail \_\_\_\_\_

2. Is there any history of epilepsy/seizure disorder or unconsciousness? Yes \_\_\_ No \_\_\_
If yes, explain in detail \_\_\_\_\_

3. Is there a history of hospitalization/surgery? Yes \_\_\_ No \_\_\_
If yes, explain in detail (when and reason) \_\_\_\_\_

4. Is student taking any medication on a regular basis? Yes \_\_\_ No \_\_\_
If yes, what medication and reason for taking it: \_\_\_\_\_

\_\_\_\_\_

5. Student may participate in **ALL** athletic activities  YES  NO

6. If **NO** is checked above, please indicate all activities in which student may participate:

Badminton _____	Football _____	Soccer _____	Track/Field _____
Baseball _____	Golf _____	Softball _____	Volleyball _____
Basketball _____	Gymnastics _____	Swimming _____	Water Polo _____
Field Hockey _____	Pep Squad _____	Tennis _____	Weight Lifting _____
		ROTC _____	Wrestling _____

Other (please specify) \_\_\_\_\_

7. List any restrictions and/or recommendations: \_\_\_\_\_

8. Is an adapted physical education program indicated? Yes \_\_\_ No \_\_\_

If yes, state reason and duration \_\_\_\_\_

9. IMMUNIZATIONS **MUST** BE UP TO DATE TO PARTICPATE IN SPORT ACTIVITES.

List dates of all immunizations given:

Td \_\_\_\_\_ MMR \_\_\_\_\_ Hepatitis B \_\_\_\_\_ Varicella \_\_\_\_\_ OPV/PV \_\_\_\_\_

Other \_\_\_\_\_ Mantoux(PPD) \_\_\_\_\_ Date Read: \_\_\_\_\_ Result: \_\_\_\_\_

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**LICENSED PHYSICIAN STATEMENT**

I have examined \_\_\_\_\_ on \_\_\_\_\_  
Student Name Date of exam

and find that he/she may participate in the physical education programs I have indicated.

\_\_\_\_\_  
Signature of licensed physician (PA **must** have physician's co-signature or name stamp of physician. NP **must** have license number.) Today's date \_\_\_\_\_

\_\_\_\_\_  
Please **PRINT** name of licensed physician and surgeon) Phone \_\_\_\_\_

Address/Facility stamp (physical will **not** be accepted without stamp)

**PLEASE RETURN THIS FORM TO THE NURSE AT \_\_\_\_\_ SCHOOL**

I have reviewed the **PHYSICAL EXAMINATION REPORT**.

\_\_\_\_\_  
Signature of school nurse Date

Comments:  
\_\_\_\_\_  
\_\_\_\_\_