Santa Barbara School Districts

Inter-scholastic Team Sports Physical Form

(C.I.F. Athletic Participation Health Form)

Student Information—to be completed by student (parent signature required at bottom)

Name _____
Last First

Address _____
Street City Zip Phone

History

1. Have you ever had (circle if yes)

allergies	asthma	seizures	heart murmur
a broken bone	diabetes	surgery	admission to a hospital

2. Do you wear corrective lenses during sports? Yes ____ No ____
3. Is your hearing normal? Yes _____ No _____
4. Do you take medication? Yes _____ No _____ If yes, what? _____
5. Please note any other medical information that school personnel may need _____

_____

Parent Permission for exam _____
Parent/Guardian signature Date

Physician Information—to be completed by physician or nurse practitioner only

Physical Examination

Height _____ Weight _____ B.P._____ / _____ Pulse _____

Code: 0=Negative X=Positive NE=No Examination

1. Ears, nose, throat	
2. Eyes—pupil equal reactive	
symmetry of eye movement	
3. Dental—missing teeth	
chipped teeth	
removable teeth	
orthodontia	
4. Lungs	
5. Heart	
6. Abdomen	
7. Hernia	

8. Musculoskeletal evaluation			
8.1 Flexibility/stability of joints			
gait		hand	
kneebend			
8.2 Spine—scoliosis			
8.3 Swelling of any joint			
8.4 Muscular weakness			
8.5 Atrophy			
thigh		shoulder girdle	
calf		arm	
9. Incoordination/loss of balance			

Additional findings, comments and/or recommendations _____

_____

"I certify that I have on this date examined this student and that, on the basis of the exam requested by the school authorities and the student's medical history as furnished to me, I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities."
If student is not medically fit to participate in athletics or if there are exceptions to the above statement, examining physician should indicate above.

Signature of Examining Physician _____ Phone _____

Print Name _____Date _____ Agency_____