Santa Barbara Unified School District

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		8. Musculoskeletal evaluation			
2. Eyes—pupil equal reactive		8.1 Flexibility/stability of joints			
symmetry of eye movement		gait		hand	
3. Dental—missing teeth		kneebend			
chipped teeth		8.2 Spine—scoliosis			
removable teeth		8.3 Swelling of any joint			
orthodontia		8.4 Muscular weakness			
4. Lungs		8.5 Atrophy			
5. Heart		thigh		shoulder girdle	
6. Abdomen		calf		arm	
7. Hernia		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_____