



ATHLETE PARTICIPATION SPORTS PHYSICAL EXAM

NAME: _____ DOB: _____ SEX: _____

ADDRESS: _____

SPORTS: _____

FAMILY PHYSICIAN: _____ PHONE: _____

HT: _____ WT: _____ BP: _____

General:

Region Examined	Satisfactory		Not Examined	Comments
	Yes	No		
Eyes				
ENT				
Dental				
Chest				
Heart				
Abdomen				
Genitalia				
Skin				
Ortho				
Neuro				
Flexibility/ Strength				

Follow-up recommendations: _____

Sports Participation approved: Yes ____ No ____ Restricted _____

Limitations: _____

Physician's Signature _____ Date: _____

Note: This form is to be completed by a Physician, Physician Assistant, or Nurse Practitioner