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 ___________________________________________________________

Address _________________________________________________________

Last First 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 ______
   knee bend ______
   8.2 Spine—scoliosis ______
   8.3 Swelling of any joint ______
   8.4 Muscular weakness ______
   8.5 Atrophy ______
   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 __________________________