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 _____
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 _____