Athletics Physical – Grades 5th through 8th

This form must be filled out and signed by a physician.

Name of Student-Athlete: _____ Date: _____

Temperature: _____ Pulse: _____ B.P. _____ Height: _____ Weight: _____

Key: P = Normal; + = Abnormal; ++ = Treatment needed

Posture		Hair		Thyroid	
Nutrition		Eyes		Heart	
Skin		Nose		Lungs	
Lymph Nodes		Ears		Abdomen	
Scars		Teeth		Liver	
Arms & Hands		Gums		Spleen	
Legs & Feet		Tongue		Kidneys	
Back		Tonsils		Hernia	

Remarks on Abnormalities: _____

_____

_____

List all drugs currently prescribed and dosage along with the reason for administration:

_____

_____

Cleared without restrictions: Yes No

Cleared, with recommendations for further evaluation or treatment for:

_____

_____

Not Cleared for – All Sports; _____ Certain sports: _____ Reason:

_____

Recommendations:

_____

_____

Name of Physician (please print or type): _____ Date:_____

Physician's Signature: _____, MD or DO

*To the Physician and Parent – This examination must be performed in the current calendar year and submitted to the office on or before the first (1st) day of school.

**Insurance calendars are factored into meeting this requirement.*