Sacramento High School
Athletics

ATHLETIC PHYSICAL EVALUATION

STUDENTS NAME: ____
DATE OF EXAM: _____/____/____
This physical examination form must be reviewed and signed by a Medical Doctor (M.D.) or Doctor of Osteopathy(D.O.) licensed by the State of California (does not include doctors of chiropractic, nurse practitioners, physician assistants).
Date of Birth_______________________
Height______ Weight ______% Body Fat (Optional) __________Pulse _______BP___/___(___/___,___/___)
Vision R20/ ___ L20/ ___ Corrected: Y or N Pupils: Equal ___ Unequal ___

	NORMAL	ABNORMAL FINDING	INITIALS
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulse			
Lungs			
Abdomen			
Genitourinary (males only)*			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand/Fingers			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			

***Having a third party present is recommended for the genitourinary examination.**

Notes:____
____
____

THIS FORM MUST BE COMPLETED IN ITS ENTIRETY IN ORDER FOR THE STUDENT TO PARTICIPATE IN AN ATHLETIC ACTIVITY.

I hereby certify ____was examined

by ____ on _____________and is presently fit to

engage in all sports except____.

Name of Doctor (print/type) ______________________________Medical Group Name________________

Address___________________________________Phone #_____________________Date_____________

Signature of Doctor____

The above student is medically able to participate in sports at this time. Any future medical issues that may occur are not held liable by the screening physician