Fairbanks North Star Borough School District
SPORTS PHYSICAL FORM

PART A: To Be Filled Out by the Athlete

Name: ___________________________   School: ___________________________   Grade: __________

Address: ___________________________   Phone Number: ___________________________

Date of Birth: ___________________________   Age: ___________________________   Name of Parents: ___________________________

Sport (s): ___________________________   Position (s): ___________________________   Coach (es): ___________________________

Please Check if you have had any problems in the following areas:

____ Concussion, “Knocked Out”   ____ Neck Injury   ____ Back Injury, Pain

____ Shoulder Injury   ____ Arm, Elbow, Hand Injury   ____ Knee Injury, Popping

____ Groin, Thigh, Leg Injury   ____ Ankle, Foot Injury   ____ Swelling, Pain, Locking or giving way

Yes   No

____ Have any members of your family under the age of 40 had a “heart attack” or sudden death?

____ Have you ever had chest pain while exercising or passed out?

____ Do you have coughing, wheezing, or severe shortness of breath with exercise?

____ Are you taking any medication?

____ Do you have any allergies?

____ Have you had ear problems or difficulty hearing?

____ Do you wear glasses or contact lenses?

____ Have you ever had any discomfort in your groin (hernia)?

____ Have you ever had any illness or injuries that required hospitalization, surgery, or repeated visits to the doctor?

PART B: To Be Filled Out by the Physician

Height: ___________________________   Weight: ___________________________   Blood Pressure: ___________________________

Eye: R 20/   L 20/   Ears: ___________________________   Skin: ___________________________   Lungs: ___________________________

Heart: ___________________________   Abdomen: ___________________________   Neurologic: ___________________________   Urinalysis (if indicated): ___________________________

MEDICAL FINDINGS

RECOMMENDATIONS

___ Follow up with athlete’s physician

___ Other

MUSCULOSKELETAL

RECOMMENDATIONS

___ Neck Weakness

___ Strengthening Exercises, Neck

___ Neck Roll (equipment)

___ Shoulder Weakness

___ Strengthening Exercises, Shoulder

___ Shoulder Injury

___ Scoliosis

___ Tight Hamstring

___ Hamstring Stretching

___ Tight Groin Muscle

___ Groin Stretching

___ Worn Knee Cap

___ Quadriceps Strengthening

___ Knee Injury; ligament, cartilage

___ Knee Brace

___ Tight Achilles Tendon

___ Achilles Stretches

___ Weak Ankles

___ Strengthening Exercises, Ankles

___ Tape or Wrap Ankles

___ Referral to Orthopedist

___ Referral to Athletic Trainer

___ Other

I certify on this date I have examined and find him/her physically able to compete in supervised activities with restrictions as noted:

Restrictions: ___________________________

PHYSICIAN’S SIGNATURE: ___________________________   DATE: ___________________________

PHYSICIAN’S NAME (Please print) ___________________________

White – School Sponsor   Yellow – Parent   Pink – Doctor   Goldenrod – School Nurse 5/28/03