Fairbanks North Star Borough School District
SPORTS PHYSICAL FORM

PART A: To Be Filled Out by the Athlete

Name: ___________________________ School: ___________________________ Grade: ___________________________
Address: _________________________ Age: ___________________________ Name of Parents: ___________________________
Date of Birth: _____________________ Position(s): ______________________ Coach(es): ___________________________

Sport(s): _________________________

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 Filed Out by the Physician

Height: ___________________________ Weight: ___________________________ Blood Pressure: ___________________________
Eye R 20/ _________________________ L20/ ___________________________ Skin: ___________________________ Lungs: ___________________________
Heart: ___________________________ Abdomen: ___________________________ Neurologic: ___________________________ Urinalysis (if indicated)

MEDICAL FINDINGS: ________________________________________________________________

RECOMMENDATIONS: ___________________________

Follow up with athlete's physician
Other

MUSCULOSKELETAL: ________________________________________________________________

RECOMMENDATIONS: ___________________________

Strengthening Exercises, Neck
Neck Roll (equipment)
Strengthening Exercises, Shoulder
Hamstring Stretching
Groin Stretching
Quadriceps Strengthening
Knee Brace
Achilles Stretches
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) ________________________________________________

Return completed original form to the school. 6/23/16