ATHLETIC PARTICIPATION MEDICAL FORM

SPORTS PHYSICAL FORM 2017 ***DATE*** _____

TO BE COMPLETED BY PHYSICIAN (SPORTS PHYSICAL IS GOOD FOR 2 SCHOOL YEARS)

Athlete's Name: _____ Grade: _____

Address: _____ DOB:_____/_____/_____

City:_____State:_____Zip: _____

Sex: Male Female Age:_____ Ht: _____ Wt: _____

BP: _____

Physical Exam:	Satisfactory	Unsatisfactory	Comment
Respiratory:	_____	_____	_____
Cardiovascular:	_____	_____	_____
Neurological:	_____	_____	_____
Extremities:	_____	_____	_____
Teeth:	_____	_____	_____
Hearing:	_____	_____	_____
Orthopedic:	_____	_____	_____
Vision:	_____	_____	_____
Skin:	_____	_____	_____

Any significant illness or injury: _____

I have examined this student athlete today and authorize him/her to engage in strenuous physical activity at CCYLAX. There are no restrictions to this athlete's participation at this time.

Physician's Signature:_____Today's Date: _____

Printed Name: _____

Office Phone #: _____