

Santa Barbara Unified School District

Inter-scholastic Team Sports Physical Form (C.I.F. Athletic Participation Health Form)

Student Information—to be completed by student (parent signature required at bottom)

Name _____
Last First

Address _____
Street City Zip Phone

History

1. Have you ever had (circle if yes)

allergies	asthma	seizures	heart murmur
a broken bone	diabetes	surgery	admission to a hospital
2. Do you wear corrective lenses during sports? Yes ____ No ____
3. Is your hearing normal? Yes ____ No ____
4. Do you take medication? Yes ____ No ____ If yes, what? _____
5. Please note any other medical information that school personnel may need _____

Parent Permission for exam _____
Parent/Guardian signature Date

Physician Information—to be completed by physician or nurse practitioner only

Physical Examination

Height _____ Weight _____ B.P. _____ / _____ Pulse _____

Code: 0=Negative X=Positive NE=No Examination

1. Ears, nose, throat	8. Musculoskeletal evaluation
2. Eyes—pupil equal reactive	8.1 Flexibility/stability of joints
symmetry of eye movement	gait
3. Dental—missing teeth	kneebend
chipped teeth	8.2 Spine—scoliosis
removable teeth	8.3 Swelling of any joint
orthodontia	8.4 Muscular weakness
4. Lungs	8.5 Atrophy
5. Heart	thigh
6. Abdomen	calf
7. Hernia	9. Incoordination/loss of balance

Additional findings, comments and/or recommendations _____

“I certify that I have on this date examined this student and that, on the basis of the exam requested by the school authorities and the student’s medical history as furnished to me, I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities.”

If student is not medically fit to participate in athletics or if there are exceptions to the above statement, examining physician should indicate above.

Signature of Examining Physician _____ Phone _____

Print Name _____ Date _____ Agency _____