

Gresham-Barlow School District Middle School Sports Physical Form – Required Every 2 Years

Student Name (Last, First, MI)	Phone	Date of Birth	Age	Gender
Home Address	City	Oregon	Zip	Student ID
School	Grade	Specific Sport		
Current Medications				
Drug Allergies				
Chronic Medical Conditions				
Height: ft. in.	Weight: lbs.	Vision: Rt: / Left: /		
Hearing Screen:		Normal Abnormal Right: <input type="checkbox"/> Right: <input type="checkbox"/> Left: <input type="checkbox"/> Left: <input type="checkbox"/>		Blood Pressure: / Pulse:
	Normal	Abnormal	Description	
General Health	<input type="checkbox"/>	<input type="checkbox"/>		
Skin	<input type="checkbox"/>	<input type="checkbox"/>		
Head	<input type="checkbox"/>	<input type="checkbox"/>		
Ears	<input type="checkbox"/>	<input type="checkbox"/>		
Eyes	<input type="checkbox"/>	<input type="checkbox"/>		
Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>		
Teeth	<input type="checkbox"/>	<input type="checkbox"/>		
Neck	<input type="checkbox"/>	<input type="checkbox"/>		
Chest	<input type="checkbox"/>	<input type="checkbox"/>		
Heart	<input type="checkbox"/>	<input type="checkbox"/>		
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>		
Spine	<input type="checkbox"/>	<input type="checkbox"/>		
Extremities	<input type="checkbox"/>	<input type="checkbox"/>		
Neurological	<input type="checkbox"/>	<input type="checkbox"/>		
Urinalysis	<input type="checkbox"/>	<input type="checkbox"/>		

I certify this person is medically able to participate in all school sports and physical activities:

- without restriction
 with the following restriction(s): _____

Physician Signature: _____ Date: _____