Athletic/Activity Physical Examination Form

Print Form

Office of Teaching and Learning
Mat-Su Borough School District
501 N. Gulkana
Palmer, AK 99645
Please send this form to your child's school

Student's Name (Print): _____ Date of Birth: _____ ☐ Male ☐ Female

School: _____ Grade: _____ ID #: _____

Parent/Guardian Name (Print): _____

Parent/Guardian Signature: _____ Date: _____

This form must be submitted to the individual school where your student will be participating in the sport or activity.

PHYSICAL EXAMINATION

** Must not expire during current athletic/activity season.**

*In accordance with ASAA regulations and School Board Policy (BP 5141.3), all physical exams must be performed and completed by a **Medical Doctor, Doctor of Osteopathy, Physician's Assistant, Nurse Practitioner, or Chiropractor.***

	Yes	No
1. Has anyone in your family died of heart problems or a sudden death before age 50?	☐	☐
2. Have you ever passed out or had chest pain during or after exercising?	☐	☐
3. Do you have trouble breathing or do you cough during or after an activity?	☐	☐
4. Have you ever had an illness or injury that required hospitalization, surgery or repeated doctor visits?	☐	☐

Explain: _____

Age	Height	Weight	Blood Pressure	Vision: R/20	Vision: L/20	Correction: Yes	No

INSTRUCTIONS: (O) if normal (X) if abnormal

1. ____ Eyes/Ears/Nose/Throat
2. ____ PERRLA
3. ____ Respiratory
4. ____ Cardiovascular
5. ____ Liver/Spleen/Abdomen
6. ____ Genitalia, Tanner Stage
7. ____ Neurological
8. ____ Skin
9. ____ Head/Neck
10. ____ Shoulders/Arms
11. ____ Knees/Hips
12. ____ Back
13. ____ Ankles
14. ____ Other Musculoskeletal
15. ____ Hearing acuity
16. ____ Lab-UA, HGB/HCT

Please explain X by indicating #

Comments: _____

I certify that I have examined this student and find him/her physically able to compete in all supervised activities **NOT** circled:

BASEBALL BASKETBALL CHEERLEADING XC RUNNING XC SKIING FOOTBALL HOCKEY MARCHING BAND

SCTP TEAM SOCCER SWIMMING/DIVING TRACK VOLLEYBALL WRESTLING WEIGHT LIFTING SOFTBALL

Printed Name of Physician: _____

Signature of Physician *(MD, DO, PA, NP, DC)*: _____ Date: _____

REV:11/06/2020