THOMPSON PUBLIC SCHOOL
HEALTH SERVICES

ATHLETIC PHYSICAL ASSESSMENT

Name: _____

Sport: *Soccer Basketball Football Baseball X Country Softball Cheerleading Golf Indoor Track Track Tennis*

Grade: ***5 6 7 8 9 10 11 12(circle please)***

Section 1: Consent for School Physical ****** Parent signature required:

I hereby give permission for my child _____ to receive a school sport physical.
Signature of Parent/ Guardian: _____ Date: _____

Section 2: Emergency Information *(Parents, please complete)*

Date: ___/___/_____ Athlete's Name: _____ DOB: _____

Parent's/ Guardian's Name: _____ Phone: _____
Emergency Contact: _____ Phone: _____
Doctor's Name: _____ Phone: _____
Doctor's Address: _____

Section 3: Additional Pertinent Information
Parent/ Student describe below any previous injuries or additional conditions that may effect this athlete's performance or treatment. Please list any current medications being taken:

_____
_____
****

Section 4: Physician's Examination Record

Pulse: _____ Rhythm: _____ Blood Pressure: _____ Wt.: _____ Ht.: _____

Heart: _____ (Check) Describe any abnormality: _____
Lungs: _____ (Check) Describe any abnormality: _____
Eyes/Nose/Ears/Throat: _____ (Check) Describe any abnormality: _____
Abdomen: _____ (Check) Describe any abnormality: _____
Hernia: No: _____ Yes: _____ Reflexes: _____
Extremities and Back: (Please indicate and history of orthopedic).
_____
_____
Urinalysis: _____ (If indicated) Blood Count: _____ (If indicated)

Tetanus (within the last five years): Specify type & date _____

I certify that I have, on this date, examined the above student and from this limited examination, he/she is approved to participate in supervised athletics. (Physician's should sign only if approved.)
Date: ____/____/_____ Physician's Signature: _____

IN CASE OF A CHANGE IN THE ABOVE INFORMATION, PLEASE NOTIFY: Coach, Ath. Dir., School Nurse

File: Athletics/ Athletic Physical Assessment