



Athletic/Activity Physical Examination Form

Office of Instruction
Mat-Su Borough School District
501 N. Gulkana
Palmer, AK 99645
P: (907) 746-9212 || F: (907) 746-9292

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 | 5. ___ Liver/Spleen/Abdomen | 9. ___ Head/Neck | 13. ___ Ankles |
| 2. ___ PERRLA | 6. ___ Genitalia, Tanner Stage | 10. ___ Shoulders/Arms | 14. ___ Other Musculoskeletal |
| 3. ___ Respiratory | 7. ___ Neurological | 11. ___ Knees/Hips | 15. ___ Hearing acuity |
| 4. ___ Cardiovascular | 8. ___ Skin | 12. ___ Back | 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: _____