

# SPORTS PHYSICAL - Mandatory Pre Participation Physical

STUDENT'S NAME \_\_\_\_\_

SCHOOL NAME \_\_\_\_\_



**Consent Form to self administer asthma medication**  
(not needed if current form is already on file with school)

**Parent Consent**

I, \_\_\_\_\_, do hereby give my son/daughter, \_\_\_\_\_, permission to self-administer his/her asthma medication as prescribed by his/her physician during athletic competition.

\_\_\_\_\_  
Parent Signature Date

**Physician Consent**

As a patient under my care, \_\_\_\_\_, is prescribed to self-administer the following asthma medication.

Medication \_\_\_\_\_

Purpose \_\_\_\_\_

\_\_\_\_\_

Dosage \_\_\_\_\_

Time/Special Circumstances \_\_\_\_\_

\_\_\_\_\_  
Physician Signature Date

**Physical Examination**

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_  
Pulse: resting \_\_\_\_\_ 15 hops \_\_\_\_\_ after 2 minutes \_\_\_\_\_  
Visual Acuity: Eyes (R) 20/ \_\_\_\_\_ w/o glasses \_\_\_\_\_ (L) 20/ \_\_\_\_\_ w/ glasses \_\_\_\_\_

Other Testing	Normal	Abnormal Findings
1. General	_____	_____
2. Skin	_____	_____
3. HEENT	_____	_____
4. Teeth (Dental Exam)	_____	_____
5. Neck	_____	_____
6. Lungs	_____	_____
7. Heart (Sit and Stand)	_____	_____
8. Abdomen	_____	_____
9. Genitalia	_____	_____
10. Musculoskeletal	_____	_____
Neck	_____	_____
Shoulder/Arm	_____	_____
Elbow/Forearm	_____	_____
Wrist/Hand	_____	_____
Back	_____	_____
Hip/Thigh	_____	_____
Knee	_____	_____
Shin/Calf	_____	_____
Ankle/Leg	_____	_____
Foot	_____	_____
11. Peripheral Pulses	_____	_____
12. Neurologic	_____	_____
13. Mental Status	_____	_____
14. Marfan Screen	_____	_____

**Other Tests (optional)**

\_\_\_\_\_ U/V \_\_\_\_\_ EKG  
 \_\_\_\_\_ % Body Fat \_\_\_\_\_ Drug Screen \_\_\_\_\_ Chest X-Ray  
 \_\_\_\_\_ Hgb/Hct \_\_\_\_\_ SMAC \_\_\_\_\_ Tanner Stage

On the basis of the examination on this day, I approve this child's participation in interscholastic sports for one year.

Yes \_\_\_\_\_ No \_\_\_\_\_ Limited \_\_\_\_\_

**Additional Comments:**

Examination Date \_\_\_\_\_ Physicians Signature \_\_\_\_\_