long beach unified school district

Nursing Services

Sport _____

CIF SPORTS EXAMINATION REPORT

(Please print or type)

Student's Name_____Grade_____
Last First Middle Initial

Birthdate _____ Age_____ Circle: Male / Female

Address_____
Street Apt. No. Zip

Home phone_____ Cell phone _____

Mother's work phone_____ Father's work phone_____

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TO BE COMPLETED BY STUDENT'S LICENSED PHYSICIAN AND SURGEON:

Blood pressure (MUST be recorded) _____S/_____D Weight_____ Height_____

Pulse: resting_____ after one minute of exercise_____ after one minute of rest_____

Vision: R_____ L_____ with or without correction (circle one) Hearing_____

Please indicate findings for <u>all</u> areas below, indicate **N** if normal and **Ab** if abnormal. Please describe in detail all abnormal findings.

Head _____	Nose _____	Chest _____	Legs _____
Neck _____	Mouth _____	Heart _____	Abdomen _____
Eyes _____	Teeth _____	Lung _____	Hernia _____
Ears _____	Throat _____	Arms _____	Joints _____
			Spine _____

Comments on any abnormal findings:

_____

_____

1. Is there any history of acute or chronic illness? Yes___ No ___
   If yes, explain in detail_____

   _____

2. Is there any history of epilepsy/seizure disorder or unconsciousness? Yes ___ No ___
   If yes, explain in detail_____

   _____

3. Is there a history of hospitalization/surgery? Yes ___ No ___
   If yes, explain in detail (when and reason)_____

   _____

4. Is student taking any medication on a regular basis? Yes ___ No ___
   If yes, what medication and reason for taking it:_____

_____

-over-

5. Student may participate in **ALL** athletic activities ☐ YES ☐ NO

6. If **NO** is checked above, please indicate all activities in which student may participate:

Badminton ____	Football ____	Soccer ____	Track/Field ____
Baseball ____	Golf ____	Softball ____	Volleyball ____
Basketball ____	Gymnastics ____	Swimming ____	Water Polo ____
Field Hockey ____	Pep Squad ____	Tennis ____	Weight Lifting ____
		ROTC ____	Wrestling ____

Other (please specify) _____

7. List any restrictions and/or recommendations: _____

_____

8. Is an adapted physical education program indicated? Yes ___ No ___

If yes, state reason and duration_____

9. IMMUNIZATIONS MUST BE UP TO DATE TO PARTICPATE IN SPORT ACTIVITES.
List dates of all immunizations given:

Td_____ MMR_____ Hepatitis B _____ Varicella _____ OPV/PV_____

Other _____ Mantoux(PPD)_____ Date Read: _____ Result: _____

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LICENSED PHYSICIAN STATEMENT

I have examined _____ on_____
Student Name Date of exam

and find that he/she may participate in the physical education programs I have indicated.

_____ Today's date_____

*Signature of licensed physician (**PA must have physician's co-signature or name stamp of physician. NP must have license number.**)*

_____ Phone_____

Please **PRINT** name of licensed physician and surgeon)

_____

Address/Facility stamp **(physical will not be accepted without stamp)**

PLEASE RETURN THIS FORM TO THE NURSE AT _____SCHOOL

I have reviewed the **PHYSICAL EXAMINATION REPORT**.

_____ _____

Signature of school nurse Date

Comments:

_____

_____