



SPORTS PHYSICAL FORM
TO BE COMPLETED BY PHYSICIAN

DATE _____

(SPORTS PHYSICAL IS GOOD FOR 2 YEARS FROM DATE RECEIVED)
PARENTS PLEASE KEEP ORIGINAL

Athlete's Name: _____ **Grade:** _____
Address: _____ **DOB:** ____/____/____
City: _____ **State:** _____ **Zip:** _____

Sex: Male **Age:** _____ **Ht:** _____ **Wt:** _____

BP: _____

Physical Exam: Satisfactory Unsatisfactory Comment

Respiratory: _____

Cardiovascular: _____

Neurological: _____

Extremities: _____

Teeth: _____

Hearing: _____

Orthopedic: _____

Vision: _____

Skin: _____

Any significant illness or injury: _____

I have examined this student athlete today and authorize him/her to engage in strenuous physical activity with the Camas Lacrosse Program. There are no restrictions to this athlete's participation at this time.

Physician's Signature: _____ **Today's Date:** _____

Printed Name: _____

Office Phone #: _____