SPORTS PHYSICAL

STUDENT NAME (Last) (First) (Middle)	**BIRTHDATE** MO DA YR	**SEX**	**GRADE LEVEL**	**SOCIAL SECURITY NUMBER**
ADDRESS (Street) (City) (Zip)	**PARENT/GUARDIAN PHONE #**		**SCHOOL**	
PARENT/GUARDIAN NAME	**ADDRESS**			

TO BE COMPLETED	**BY PHYSICIAN**
REQUIRED HEIGHT WEIGHT B/P	*Lead Assessment Date Lead Screening Indicated? YES ☐ NO ☐ Results _____

STRONGLY RECOMMENDED	**DATE**	**RESULTS**	Needs/modifications required in the school setting
Hemoglobin			Medications
Hematocrit			Dietary
Urinalysis			Special Equipment
Sickle Cell (as needed)			Other
TB skin test (as indicated)			* Mandated for state licensed childcare facilities or approved schools and programs

PHYSICAL EXAMINATION			**REQUIREMENTS**		
	(Normal)	Comments/Follow up		(Normal)	Comments/Follow up
Skin			Genito-Urinary		
Ears			Neurological		
Eyes			Musculoskeletal		
Nose			Spinal Examination		
Throat			Nutritional Status		
Mouth/Dental			Mental Health		
Cardiovascular			General Comments:		
Gastrointestinal					

PHYSICIANS NAME (print)	PHYSICIANS SIGNATURE & DATE
PHYSICIAN'S ASSISTANT NAME (print)	PHYSICIAN'S ASSISTANT SIGNATURE & DATE*:
ADVANCED NURSE PRACTIONER'S NAME (print)	ADVANCED NURSE PRACTIONER'S SIGNATURE & DATE*:

ON THE BASIS OF THE EXAMINATION ON THIS DAY, I APPROVE THIS CHILDS PARTICIPATION IN:
(If no or modified, please attach explanation).

PHYSICAL EDUCATION: YES ☐ NO ☐ MODIFIED ☐

INTERSCHOLASTIC SPORTS (for one year): YES ☐ NO ☐ LIMITED ☐

*effective January 2003, the IHSA Board of Directors approved a recommendation, consistent with the Illinois School Code, that allows Physician's Assistants or Advanced Nurse Practitioners to sign off on physicals.