

SPORTS PHYSICAL

STUDENT NAME			BIRTHDATE	SEX	GRADE LEVEL	SOCIAL SECURITY NUMBER
(Last)	(First)	(Middle)	MO DA YR			
ADDRESS			PARENT/GUARDIAN PHONE #		SCHOOL	
(Street)	(City)	(Zip)				
PARENT/GUARDIAN NAME			ADDRESS			
TO BE COMPLETED			BY PHYSICIAN			
REQUIRED	HEIGHT	WEIGHT	B/P	*Lead Assessment Date		Lead Screening Indicated? YES <input type="checkbox"/> NO <input type="checkbox"/>
			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 PRACTITIONER'S NAME (print)			ADVANCED NURSE PRACTITIONER'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.