



ATHLETIC PHYSICAL FORM 2025-2026

(Exam MUST be completed on or after Friday, June 6, 2025)

**Must be completed by a Physician (MD/DO), Physician's Assistant (PA), or Nurse Practitioner (NP), licensed in the State of California.*

NAME:

GRADE:

DATE OF EXAM:

DATE OF BIRTH:	HEIGHT:	WEIGHT:	SEX: <input type="checkbox"/> MALE / <input type="checkbox"/> FEMALE
SPORTS:			

VITAL SIGNS

BLOOD PRESSURE:	PULSE:	RESPIRATIONS:
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VISION

RIGHT EYE:	LEFT EYE:	PERL:
TESTED WITH CORRECTIVE LENSES: <input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> GLASSES <input type="checkbox"/> CONTACTS

PHYSICAL EXAM

	NORMAL	ABNORMAL	COMMENTS
APPEARANCE/SKIN			
EYES/EARS/NOSE/THROAT			
HEAD/NECK/LYMPHATICS			
CARDIOVASCULAR			
RESPIRATORY			
GASTROINTESTINAL			
GENITAL/URINARY			
MUSCULOSKELETAL			
NEUROLOGICAL			

PHYSICIAN CLEARANCE (MUST check one)

<input type="checkbox"/>	CLEARED FOR UNLIMITED PARTICIPATION / NO RESTRICTIONS	
<input type="checkbox"/>	LIMITED PARTICIPATION	EXPLAIN:
<input type="checkbox"/>	WITHHELD FROM PARTICIPATION	EXPLAIN:

I have reviewed the medical history and given a thorough physical examination to the above-named student. I certify that all the important medical information has been included, and the information is complete and accurate.

PHYSICIAN'S SIGNATURE:

DATE:

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PHYSICIAN'S NAME (printed):

PHONE NUMBER:

PHYSICIAN'S STAMP or BUSINESS CARD (REQUIRED):

ROLL DON'S