



**Athletic/Activity Physical Examination Form**

Mat-Su Borough School District  
501 N. Gulkana  
Palmer, AK 99645  
P: (907) 746-9200 || F: (907) 761-4076

Student's Name (Print): \_\_\_\_\_ Date of Birth: \_\_\_\_\_  Male  
 Female  
School: \_\_\_\_\_ Grade: \_\_\_\_\_ ID #: \_\_\_\_\_  
Parent/Guardian Name (Print): \_\_\_\_\_  
Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

This form must be submitted to the individual school where your student will be participating in the sport or activity.

**PHYSICAL EXAMINATION**

**\*\* Must not expire during current athletic/activity season.\*\***

*In accordance with ASAA regulations and School Board Policy (BP 5141.3), all physical exams must be performed and completed by a **Medical Doctor, Doctor of Osteopathy, Physician's Assistant, Nurse Practitioner, or Chiropractor.***

- |  |     |     |
|--|-----|-----|
|  | Yes | No  |
| 1. Has anyone in your family died of heart problems or a sudden death before age 50?.....                        | ___ | ___ |
| 2. Have you ever passed out or had chest pain during or after exercising?.....                                   | ___ | ___ |
| 3. Do you have trouble breathing or do you cough during or after an activity?.....                               | ___ | ___ |
| 4. Have you ever had an illness or injury that required hospitalization, surgery or repeated doctor visits?..... | ___ | ___ |

Explain: \_\_\_\_\_

Age	Height	Weight	Blood Pressure	Vision: R/20	Vision: L/20	Correction: Yes No	

**INSTRUCTIONS:** (O) if normal (X) if abnormal

- |                              |                                |                        |                               |
|------------------------------|--------------------------------|------------------------|-------------------------------|
| 1. ___ Eyes/Ears/Nose/Throat | 5. ___ Liver/Spleen/Abdomen    | 9. ___ Head/Neck       | 13. ___ Ankles                |
| 2. ___ PERRLA                | 6. ___ Genitalia, Tanner Stage | 10. ___ Shoulders/Arms | 14. ___ Other Musculoskeletal |
| 3. ___ Respiratory           | 7. ___ Neurological            | 11. ___ Knees/Hips     | 15. ___ Hearing acuity        |
| 4. ___ Cardiovascular        | 8. ___ Skin                    | 12. ___ Back           | 16. ___ Lab-UA, HGB/HCT       |

Please explain X by indicating #

Comments: \_\_\_\_\_

I certify that I have examined this student and find him/her physically able to compete in all supervised activities **NOT** circled:

- |           |            |                 |            |            |           |                |               |
|-----------|------------|-----------------|------------|------------|-----------|----------------|---------------|
| BASEBALL  | BASKETBALL | CHEERLEADING    | XC RUNNING | XC SKIING  | FOOTBALL  | HOCKEY         | MARCHING BAND |
| SCTP TEAM | SOCCER     | SWIMMING/DIVING | TRACK      | VOLLEYBALL | WRESTLING | WEIGHT LIFTING | SOFTBALL      |

Printed Name of Physician: \_\_\_\_\_

Signature of Physician (MD, DO, PA, NP, DC): \_\_\_\_\_

Date: \_\_\_\_\_