Elk Grove Unified School District

2025-2026

Risk Management Department

SPORTS PHYSICAL EXAMINATION FORM

PART 1 (TO BE COMPLETED BY A PARENT OR LEGAL GUARDIAN)

LAST NAME	FIRST NAME	GRADE

BIRTHDATE	FALL SPORT	WINTER SPORT	SPRING SPORT	STUDENT ID NUMBER

PART 1 -- HEALTH HISTORY (Must be Completed by Parent/Guardian Prior to the Examination)

Yes	No	Has this student had:
☐	☐	1. Chronic or recurrent illness?
☐	☐	2. Illness lasting oveweek?
☐	☐	3. Hospitalizations or Surgeries?
☐	☐	4. Nervous, psychiatric, or neurologic condition?
☐	☐	5. Loss or nonfunctioning of organs (eye, kidney, liver, testicle) or glands?
☐	☐	6. Allergies (medicines, insect bites, food)?
☐	☐	7. Problems with heart or blood pressure?
☐	☐	8. Chest pain or significant or severe shortness of breath during or after exercise?
☐	☐	9. Headaches, dizziness or fainting with exercise?
☐	☐	10. Fainting, bad headaches or convulsions?
☐	☐	11. Potential head injury, concussion or loss of consciousness?
☐	☐	12. A hit or blow to the head causing confusion, prolonged headache or memory problems?
☐	☐	13. Numbness, tingling, weakness or inability to move your arms or legs after being hit or falling?
☐	☐	14. History of migraine headaches or sleep disturbances?
☐	☐	15. Heat exhaustion, heatstroke, or other problems managing or responding to heat?
☐	☐	16. Racing heartbeat, skipped or irregular heartbeats, or heart murmur?
☐	☐	17. Seizures or seizure disorders?
☐	☐	18. Severe or repeated instances of muscle cramps?
☐	☐	19. Injuries requiring medical care or treatment?
☐	☐	20. Neck or back pain or injury?
☐	☐	21. Knee pain or injury?
☐	☐	22. Shoulder or elbow pain or injury?
☐	☐	23. Ankle pain or injury?
☐	☐	24. Other joint pain or injury?
☐	☐	25. Broken bones (fractures)?
		Does this student presently:
☐	☐	26. Wear eyeglasses or contact lenses?
☐	☐	27. Wear dental bridges, braces or plates?
☐	☐	28. Take any medications? (List below):
		Further history:
☐	☐	29. Birth defects (corrected or not)?
☐	☐	30. Death of a parent or grandparent less than 40 years of age due to medical cause or condition?
☐	☐	31. Parent or grandparent requiring treatment for heart condition less than 50 years of age?
☐	☐	32. Been seen by a physician on an emergency or urgent basis in the last 12-months?

Date of last known tetanus (lockjaw) shot: _____ *Date of last complete physical examination:* _____

Explain all "YES" answers. Describe any other fact that should be disclosed prior to the examination (use reverse of form if needed):

PARENT/GUARDIAN'S AUTHORIZATION: I authorize the health care provider to perform a Sports Physical Evaluation on the student. The information set forth above is complete and accurate. I presently know of no reason why the student cannot fully and safely participate in the listed sports. For Sports Physical Evaluations that may be performed by District volunteers, I understand the evaluation is a screening evaluation only, and that I must address all health care concerns with the Student's personal physician or health care provider.

PRINT NAME OF PARENT OR GUARDIAN	SIGNATURE OF PARENT OR GUARDIAN		
ADDRESS	WORK PHONE	HOME PHONE	DATE
REGULAR PHYSICIAN'S NAME	OFFICE PHONE	PROVIDER CLINIC OR ORGANIZATION	

PART 2 – MEDICAL EVALUATION (TO BE COMPLETED BY THE EXAMINING HEALTH CARE PROVIDER)

This Evaluation Can Only be Performed by Medical Doctors (MDs), Doctors of Osteopathy (DOs), Physician's Assistants (P.A.s), and Nurse Practitioners (N.P.s)

	NORMAL	ABNORMAL (Describe)	(May be contained on Provider's Form)
Eyes/Ears/Nose/Throat			Height: Weight:
Heart, lungs, pulmonary function			Pulse: After Ex:
Abdomen, genital/hernia (males)			BP:
Skin and Musculoskeletal:			**Recommendation:**
a. Neck/Spine/Shoulders/Back			☐ Unlimited participation
b. Arms/Hands/Fingers			☐ Limited participation/specific sports, events or activities
c. Hips/Thighs/Knees/Legs			☐ Clearance withheld pending further testing/evaluation
d. Feet/Ankles			☐ No athletic participation
Neurologic Screening Exam (NSE)/			One of the above MUST be checked.
Concussion Screening Evaluation (only if needed based on above info.)			

Comments:

PHYSICIAN STAMP

PRINT NAME OF PHYSICIAN	PHYSICIAN'S SIGNATURE	DATE

Original to be held on file with the Athletic Director for a period of one (1) year after the end of the Academic Year.