ONTARIO CHRISTIAN SCHOOL – SPORTS PHYSICAL FORM

-To be completed by a licensed physician-

Student's Name _____Grade in September_____ Date of Birth_____

Height_____ Weight_____ Pulse_____ BP_____ / _____

Vision R 20/_____ L 20/_____ Corrected: Yes No Pupils: Equal_____ Unequal_____

	NORMAL	ABNORMAL FINDINGS
MEDICAL		
General Appearance		
Nutritional status		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		
Musculoskeletal		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand		
Hip/thigh		
Knee		
Leg/ankle/foot		

Other restrictions (if any) are: _____

_____

Recommendations for additional Medical/Vision/Dental Care: _____

_____

This individual is cleared to participate in any and all sports offered at Ontario Christian School.

YES_____ **NO**_____

PHYSICIAN'S CLEARANCE TO PARTICIPATE:

In my opinion, he/she is qualified to participate in Ontario Christian School's athletic program:

_____ _____

Print Name of Licensed Physician Signature of Licensed Physician

_____

Street City Zip

_____

Telephone Fax Number Date

Make Copies of All Documents! Retain for your records!