INTERSCHOLASTIC SPORTS EXAMINATION

BISHOP LOUGHLIN MEMORIAL HIGH SCHOOL
357 CLERMONT AVENUE
BROOKLYN, NY 11238

MUST BE SUBMITTED TO NURSE OFFICE BEFORE PLAYING SPORTS!

HOMEROOM _____ GRADE _____

STUDENT LAST NAME _____ STUDENT FIRST NAME _____ STUDENT MIDDLE INITIAL _____ ☐ MALE ☐ FEMALE DATE OF BIRTH (MM-DD-YYYY) _____

STUDENT STREET _____ APT # _____ STUDENT CITY _____ STATE _____ ZIP CODE _____

PARENT NAME _____ RELATIONSHIP TO STUDENT _____ HOME PHONE _____ CELL PHONE/EMERGENCY PHONE _____

PARENTAL PERMISSION FOR PARTICIPATION IN BISHOP LOUGHLIN SPORTS PROGRAMS

I give permission for _____ to participate in all Athletic Programs.

Signature _____ Date_____

PHYSICAL EXAMINATION - TO BE FILLED OUT BY HEALTH CARE PROVIDER

Height: _____ Weight: _____ Pulse: _____ Blood Pressure: _____

Vision Uncorrected: L20/____ R20/____ Corrected: L20/____ R20/____

	Normal	Abnormal	Comments
Skin	_____	_____	_____
Eyes	_____	_____	_____
ENT	_____	_____	_____
Mouth & Teeth	_____	_____	_____
Neck	_____	_____	_____
Cardiovascular	_____	_____	_____
Lungs, Chest	_____	_____	_____
Spine	_____	_____	_____
Abdomen	_____	_____	_____
Genitalia (Hernia)	_____	_____	_____

Maturation Index _____

Extremities

Orthopedic	_____	_____	_____
Neuromuscular	_____	_____	_____

Other tests, if done (Lab, ECC, ect.)

DATE OF LAST TETANUS BOOSTER: _____

Assessment: Plan:

CLINICIAN'S RECOMMENDATIONS

Based on the physical examination above, the student may participate in the following sports:

Flag Football	Weight Training	Bowling	Volleyball
Football	Track & Field	Baseball	Soccer
Basketball	Cross-Country	Handball	
Lacrosse	Cheerleading	Softball	

MUST BE MECHANICALLY STAMPED

Physician's Name:
Name of Facility:
Address:
Phone #:

Physician Signature: _____
Date of Examination: ___/___/___