

\_\_\_\_\_  
Please print name Last

\_\_\_\_\_  
First

\_\_\_\_\_  
Middle

\_\_\_\_\_  
Sex

\_\_\_\_\_  
Grade

\_\_\_\_\_  
Birth Date

**FAITH CHRISTIAN SCHOOL  
ATHLETICS PHYSICAL FORM**

(To be filled out and signed by the examining **physician**)

Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ Eyes: R \_\_\_\_\_ L \_\_\_\_\_ Contact Lens \_\_\_\_\_ Glasses \_\_\_\_\_

Ears: R \_\_\_\_\_ L \_\_\_\_\_ Hearing: R \_\_\_\_\_ L \_\_\_\_\_ Skin \_\_\_\_\_ Mouth \_\_\_\_\_ Teeth \_\_\_\_\_

Heart \_\_\_\_\_ Lungs \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_

Abdomen \_\_\_\_\_ Hernia \_\_\_\_\_

Spine \_\_\_\_\_ Upper Extremity \_\_\_\_\_

Lower Extremity \_\_\_\_\_

Urine Analysis \_\_\_\_\_ Miscellaneous \_\_\_\_\_

I hereby certify that I have on this date examined the above student and I have found no medical reason to disqualify him/her from participating in all supervised athletics and physical education activities EXCEPT AS CROSSED OUT BELOW:

INTERSCHOLASTIC SPORTS

Volleyball  
Soccer  
Basketball

\_\_\_\_\_  
NAME OF PHYSICIAN (print or type)

\_\_\_\_\_  
(MD / DO)

\_\_\_\_\_  
SIGNATURE OF EXAMINING PHYSICIAN

\_\_\_\_\_  
DATE