# Arizona Disabled Sports
# Athlete Participation Sports Physical Exam

Name:_____ Age:_____ Sex: M F

Address:_____

Sports:_____ Disability:_____

Family Physician:_____ Phone:_____

HT:_____ WT:_____ BP:_____

General:

| Region Examined | Satisfactory | | | Comments |
|---|---|---|---|---|
| | Yes | No | Not Examined | |
| Eyes | | | | |
| ENT | | | | |
| Dental | | | | |
| Chest | | | | |
| Heart | | | | |
| Abdomen | | | | |
| Genitalia | | | | |
| Skin | | | | |
| Ortho | | | | |
| Neuro | | | | |
| Flex/Strength | | | | |

Follow-up recommendations:_____

Sports Participation approved: [ ] Yes [ ] No Restricted_____

Limitations:_____

Physician's Signature:_____ Date:_____

Name of Physician's Practice:_____ Phone:_____

Note: This form is to be completed by a Physician, Physician Assistant or Nurse Practitioner.