



# 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.