Anchorage School District
Sports Physical - Health Examination Form

MEDICAL HISTORY TO BE COMPLETED BY LEGAL PARENT/GUARDIAN

Last Name (print)_____ First Name _____ Initial

Consent information:

- I hereby consent to emergency treatment, hospitalization or other medical treatment as may be necessary by a physician, qualifed nurse, or hospital in the event of an injury or illness.
- I hereby consent to participation in ASAA approved interscholastic activities.
- I hereby consent to travel to and from ASAA activities via school approved transportation.
- I hereby waive on behalf of myself and the above student any liability of the school or ASAA organizationally or for any of its offcers, agents or employees for injuries sustained in the interscholastic program.
- I accept fnancial responsibility for the above student in the event of an injury or illness.
- I hereby state that information submitted on this form is true.
- I hereby consent to abiding by the ASAA rules and regulations and school handbook.
- I understand that the medical information disclosed by the medical provider to the school may be further disclosed by the school to the school's administrators, athletic director, coaches and athletic trainers of any interscholastic activities in which I seek to participate.

Student Signature _____ Parent Signature _____ Date _____

HEALTH EXAMINATION TO BE COMPLETED BY HEALTHCARE PROVIDER - MD, DO, ANP, PA

Age _____ Height _____ Weight _____ Blood Pressure _____

Vision R/20 _____ Vision L/20 _____

Circle any of the following that are abnormal and explain under "comments":

Eyes/ears/nose/throat	Genitalia, Tanner stage_____	Knee/hip
PERRLA	Neurological	Back
Respiratory	Skin	Ankles
Cardiovascular	Head/neck	Other musculoskeletal
Liver/spleen/abdomen	LAB: UA, HGB/HCT (as needed)	DT (date): _____

Comments: _____

Baseball	Football	Softball	Wrestling
Basketball	Gymnastics	Swimming	XC running
Bowling	Hockey (boys)	Tennis	XC skiing
Cheer	Hockey (girls)	Track & Field	
Diving	Rifery	Volleyball	
Flag Football	Soccer	Weight Training	

HCP Name (MD, DO, ANP, PA) (print) _____

Signature _____ Date of exam _____

Address _____ Healthcare provider stamp is required here

City _____ State _____

Phone _____ Zip _____