

**St. John's Athletic Association
Physical Examination Form**

Name of Participant:(Please Print)_____

Sport to Participate in:_____

Name of Parents/Guardians:_____

Phone Number:_____

Parent or Guardian: This section will be completed by the Doctor performing the physical and kept on file in the Athletic Office.

List Known Allergies_____

Height:_____ Weight:_____ Pulse:_____ Resp:_____

Blood Pressure:_____ HEENT:_____

Neck:_____ Abdomen:_____

Back:_____ Lungs:_____ Skin:_____

Ext:_____ Neuro:_____ Heart:_____

Recommendations/Restrictions:_____

Medications:_____

Signature: Dr. _____, M.D. Date:_____

Phone #:_____