

SCHOOL PHYSICAL EXAMINATION FORM

Name _____ Sex _____ Date of Birth _____ Grade _____
 Address _____ Parent _____
 _____ Phone _____
 Date: _____ Height _____ Weight _____ Blood Pressure _____
 Vision R ____ / ____ L ____ / ____ Glasses Y/N Contacts Y/N

Please explain all abnormal responses	Normal	Abnormal	Please explain all abnormal responses	Normal	Abnormal
NUTRITION			HEART		
SKIN			LUNGS		
EYES			ABDOMEN		
EARS			HERNIA		
NOSE			GENITALIA		
THROAT			BONES AND JOINTS		
TEETH			SCOLIOSIS		
THYROID			TANNER STAGE 1 2 3 4 5		
NODES			OTHER:		

DTaP	MMR
POLIO	HEP B
VARICELLA VACCINE	VARICELLA DATE OF DX
TETANUS	OTHER

IMMUNIZATIONS: KINDERGARTEN COMPLETE SERIES, OTHER GRADES UPDATE NEW IMMUNIZATIONS ONLY.

Please list any chronic illnesses, allergies, and medications: _____

Physician signature: _____ **Date:** _____

FOR SPORTS PARTICIPATION ONLY

	Normal	Abnormal		Normal	Abnormal
NECK			QUAD/HAMSTRING		
SHOULDER			ANKLE/FEET		
ELBOW			BACK/SPINE		
HANDS			TOE HEEL WALK		
WRIST			DUCK WALK		
KNEES					

This student has been evaluated in the following areas and has been found physically able to participate in school interscholastic activities. (circle yes or no)

MEDICAL HISTORY	Yes	No	MEDICAL EXAMINATION	Yes	No	MUSCOSKELETAL EXAMINATION	Yes	No

	Cleared	Not Cleared	Modifications or Exceptions
Collision Sports			
Contact Sports			
Non-contact Sports			

Attending Physician Name: _____ **Signature** _____ **Date** _____

HEALTH HISTORY
(To be completed before examination)

		Yes	No
1.	Have you ever had an illness that required hospitalization or that lasted longer than a week?		
2.	Have you ever had an illness or injury that caused you to miss 3 days of practice or competition?		
3.	Have you ever had an illness related to allergies? (hives, insect stings, asthma, hay fever)		
4.	Have you ever had surgery?		
5.	Do you have any chronic illnesses? Circle any of the following that you have had: asthma / abnormal bleeding / bruising / broken bones / dislocation / heart murmur / palpitations / high blood pressure / rheumatic fever / seizures / anemia / diabetes / hearing impairment / hepatitis / jaundice / loss of eye sight / scoliosis / sickle-cell disease / undescended testicle / other		
6.	Have you ever had an injury requiring hospitalization?		
7.	Have you ever had an injury that required x-rays?		
8.	Do you take any medication? (include vitamins and nonprescription medications)		
9.	Have any members or your family under age 50 years had a heart attack, heart problem, or died unexpectedly?		
10.	Have you ever been dizzy, had chest pain or passed out during or after exercise?		
11.	Have you ever been unconscious or had a concussion?		
12.	Are you able to run ½ mile without stopping?		
13.	Do you wear eyeglasses or contacts?		
14.	Do you wear dental bridges, braces or plates?		
15.	Have you ever had a heart murmur, high blood pressure or a heart abnormality?		
16.	Do have any allergies to medications?		
17.	Are you missing a kidney, eye, testicle or ovary?		
18.	When was your last tetanus booster? _____		
19.	For Women At what age did you experience your first menstrual period? In the last year, what is the longest time you have gone between periods?		
20.	Explain any "yes" answers _____ _____ _____		
21.	In which sports do you wish to participate? _____		
22.	Do you have any concerns about your health? _____ _____ _____		

I do not know of any existing physical condition or additional health reason that would preclude participation in sports. I certify that the answers to the above questions are true and accurate. I approve participation in athletic activities. I hereby release to the school nurse the information contained in this document. I also give permission for the exchange of information between the doctor and the school nurse.

Parent of Guardian: _____ **Date:** _____