Physical/Health Form for Athletics (Boys and Girls)

Entering Grade_____ YR 20_____

CHILD'S NAME: _____ SEX: M F DOB_____
FIRST MI LAST MO/DAY/YEAR

ADDRESS: _____
STREET CITY ZIP

MOTHER'S NAME: _____ PHONE:_____
FIRST MI LAST HOME/WORK

FATHER'S NAME: _____ PHONE:_____
FIRST MI LAST HOME/WORK

IN CASE OF EMERGENCY IN WHICH THE PARENT'S CANNOT BE REACHED, PLEASE CALL:

NAME RELATIONSHIP PHONE

_____

********** SPECIAL EMERGENCY REFERRAL INSTRUCTIONS **********

IN THE EVENT I CANNOT BE REACHED OR MAKE ARRANGEMENTS FOR EMERGENCY MEDICAL ATTENTION AT THE TIME OF ILLNESS OR ACCIDENT, I HEARBY AUTHORIZE _____

TO TAKE MY CHILD TO: _____
DOCTOR ADDRESS PHONE

_____
HOSPITAL / CLINIC ADDRESS

1) Has this child: (please explain any yes answers)

a) had any chronic illnesses – i.e., Diabetes, Cystic Fibrosis YES: _____ NO: _____

b) had any allergies that require special attention or medication YES: _____ NO: _____

c) had any past history of head injury, concussions, seizure, etc. YES: _____ NO: _____

d) had any heart or blood pressure abnormalities YES: _____ NO: _____

e) had any spinal injuries or spinal defects of any kind YES: _____ NO: _____

f) need for medication at school YES: _____ NO: _____

2) Are there any special concerns that you have regarding athletic participation for your child?

_____

Are there any limitations for your child's participation in physical education or sports?

_____

DATE OF LAST DT: _____

PARENT SIGNATURE: _____

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THIS SIDE TO BE COMPLETED BY PHYSICIAN

STUDENTS NAME (PLEASE PRINT) _____

RELEVANT HEALTH INFORMATION	PHYSICAL ASSESSMENT	NORMAL	ABNORMAL	NOT EXAMINED
PRESENT AGE:	GENERAL APPEARANCE			
HEIGHT (NO SHOES):				
WEIGHT (LIGHT CLOTHING)	SKIN			
	REFLEX TEST			
OTHER:	COVER TEST			
	EARS			
	NOSE, MOUTH, PHAYNX, TEETH			
	NECK (LYNPHATIC/THYROID)			
	HEART			
	LUNGS			
	ABDOMEN (INCLUDES HERNIAS)			
	GENITALIA			
	ORTHOPEDIC			
	NEUROLOGIC			

ABNORMAL FINDINGS:

PATIENT HEALTH HISTORY, FINDINGS AND RECOMMENDATIONS:

PHYSICAL ACTIVITY: RESTRICTED OR UNRESTRICTED – EXPLANATION:

I have examined the child named on this form and find that he/she is able to participate in the athletic programs of the school:

DATE: _____ SIGNATURE: _____

PRINTED PHYSICIAN'S NAME AND ADDRESS:

_____

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