					Physical/Health Form for Athletics (Boys and Girls)								
					Enteri	ng Grade	YR 20						
CHILD'S NAME:			LAST	SEX: M	F DOB								
ADDRESS:	STREET		CITY		ZIP								
				PHONE:									
MOTHER'S NAME:	FIRST	MI	LAST	PHONE:_	НО	ME/WORK							
FATHER'S NAME	B:		LAST	PHONE:									
	FIRST	MI	LAST		HO.	ME/WORK							
N CASE OF EME	RGENCY IN WH	ICH THE PARI	ENT'S CANNOT BI	E REACHED,	PLEASE CAI	L:							
NAME			RELATIO1	MCHID		PHONE							
			KELATIO	NSIIII		THONE							
ГО ТАКЕ МҮ СН	ILD TO:	OCTOR	ADDRESS	<b>S</b>	PHONE								
ГО ТАКЕ МҮ СН		OCTOR L / CLINIC		DDRESS	PHONE								
	HOSPITA	L / CLINIC	Al		PHONE								
		L / CLINIC	Al										
1) Has this ch	HOSPITA	L / CLINIC	Alers)			S:	NO:						
1) Has this change a) had any	HOSPITA	in any yes answer-i.e., Diabetes,	Alers)		YES	S:							
1) Has this changed a) had any b) had any	HOSPITA nild: (please explain chronic illnesses - allergies that requires	L / CLINIC  In any yes answer  - i.e., Diabetes, on the control of	ers) Cystic Fibrosis		YES YES		NO:						
1) Has this changed a) had any b) had any c) had any	HOSPITA nild: (please explain chronic illnesses - allergies that requires	L / CLINIC  In any yes answer  - i.e., Diabetes, or  nire special attental injury, concus	ers)  Cystic Fibrosis  tion or medication ssions, seizure, etc.		YES YES	S:	NO:						
a) had any b) had any c) had any d) had any	HOSPITA nild: (please explain chronic illnesses - allergies that require past history of heat	L / CLINIC  In any yes answer  i.e., Diabetes, or  ire special attentad injury, concur-  essure abnormalia	ers)  Cystic Fibrosis  tion or medication ssions, seizure, etc.		YES YES YES	S:	NO: NO:						
a) had any b) had any c) had any d) had any e) had any	HOSPITA nild: (please explain chronic illnesses - allergies that require past history of heart or blood presented in the chart	in any yes answer-i.e., Diabetes, on the special attental injury, concursives and injury, concursives abnormaliate spinal defects of	ers)  Cystic Fibrosis  tion or medication ssions, seizure, etc.		YES YES YES YES	S: S:	NO: NO: NO:						
a) Has this changed and any b) had any c) had any d) had any e) had any f) need for	HOSPITA nild: (please explain chronic illnesses - allergies that require past history of heat heart or blood prespinal injuries or a medication at sch	L / CLINIC  In any yes answer  i.e., Diabetes, on  the special attent  ad injury, concust  essure abnormalians  spinal defects of	ers)  Cystic Fibrosis  tion or medication ssions, seizure, etc.	DDRESS	YES YES YES YES YES	S: S: S:	NO: NO: NO:						
a) Has this changed and any b) had any c) had any d) had any e) had any f) need for 2) Are there a	HOSPITA  nild: (please explai chronic illnesses - allergies that requ past history of hea heart or blood pre spinal injuries or s medication at sch any special concern	L / CLINIC  In any yes answer  i.e., Diabetes, on  ire special attent  ad injury, concur  essure abnormali  spinal defects of  ool  ns that you have	ers)  Cystic Fibrosis tion or medication ssions, seizure, etc. ities  any kind	DDRESS articipation for	YES YES YES YES YES	S: S: S:	NO: NO: NO:						
a) had any b) had any c) had any d) had any e) had any f) need for 2) Are there a	HOSPITA  nild: (please explain chronic illnesses - chronic illness	L / CLINIC  In any yes answer  - i.e., Diabetes, on  the special attent  and injury, concust  essure abnormalic  spinal defects of  ool  ns that you have  your child's par	Cystic Fibrosis tion or medication ssions, seizure, etc. ities f any kind regarding athletic pa	DDRESS articipation for	YES YES YES YES YES YES YES your child?	S: S: S: S:	NO: NO: NO: NO:						

RELEVANT HEALTH INFORMATION	PHYSICAL ASSESSMENT	NORMAL	ABNORMAL	NOT EXAMINEI
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 A	AND RECOMMENDATIONS:			
PHYSICAL ACTIVITY: RESTRICTED OR	UNRESTRICTED – EXPLANATIO	ON:		
I have examined the child named on programs of the school:	this form and find that he/sh	ne is able to pa	nrticipate in the	e athletic
DATE:	SIGNATURE:			
PRINTED PHYSICIAN'S NAME A	ND ADDRESS:			
Rev. 8/1/2007				

THIS SIDE TO BE COMPLETED BY PHYSICIAN