



## Physical Examination

To parents & legal guardians: To provide the best educational experience, school personnel must understand your son's health needs. This form requests this information from you (Part 1) which will also be helpful to the licensed health care provider when he/she completes the Physical Examination Report (Part 2). This form may also be used for health assessments required every year for students participating in interscholastic sports.

### PART 1: MEDICAL HISTORY AND PARENTAL CONSENT

This part of the form must be completed by the student's parents or legal guardians prior to the student's physical examination. The information will be reviewed by the physician or licensed physician assistant during the examination. Please print using blue or black ink.

Student Name (Last Name, First Name) \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Current Grade \_\_\_\_\_ Sex \_\_\_\_\_

Father's Name (or legal guardian) \_\_\_\_\_ Phone Number \_\_\_\_\_ Mother's Name (or legal guardian) \_\_\_\_\_ Phone Number \_\_\_\_\_

Please check the appropriate box indicating if the student has any history of the listed condition. If yes, please indicate age or date of condition:

	Yes	No	When?		Yes	No	When?
Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>		Breathing or Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>		Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Disease or Problems	<input type="checkbox"/>	<input type="checkbox"/>		German Measles	<input type="checkbox"/>	<input type="checkbox"/>	
Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>		Measles	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>		Anemia	<input type="checkbox"/>	<input type="checkbox"/>	
Bone or Joint Problems	<input type="checkbox"/>	<input type="checkbox"/>		Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	
Bone Fractures	<input type="checkbox"/>	<input type="checkbox"/>		Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	
Skin Disease or Problems	<input type="checkbox"/>	<input type="checkbox"/>		Mumps	<input type="checkbox"/>	<input type="checkbox"/>	
Severe Headaches	<input type="checkbox"/>	<input type="checkbox"/>		Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	
Dizziness or Unconsciousness	<input type="checkbox"/>	<input type="checkbox"/>		Hernia Rupture	<input type="checkbox"/>	<input type="checkbox"/>	
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>		Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	
Head Injuries or Concussion	<input type="checkbox"/>	<input type="checkbox"/>		Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	

Does the student have any long term disability?  Yes  No If yes, please specify: \_\_\_\_\_

Does the student have any allergies?  Yes  No If yes, please specify: \_\_\_\_\_

Is the student currently taking any medication?  Yes  No If yes, please specify: \_\_\_\_\_

Has the student ever been hospitalized?  Yes  No If yes, please explain: \_\_\_\_\_

#### Parent or Legal Guardian Consent

I hereby give my permission for the physician or licensed physician assistant to examine my son, as named above, so that he may obtain health/medical clearance to participate in the school activities, including physical education classes, National Junior ROTC and/or interscholastic athletics. Therefore, the examining health care provider, Father Dueñas Memorial School, and IIAAG will not be liable for any abnormalities not detected in this examination.

I understand that this clearance neither obligates nor guarantees my son's participation in school activities and that participation in any school activity may involve additional requirements.

Signature of Parent/Legal Guardian \_\_\_\_\_

Print Name \_\_\_\_\_

Date \_\_\_\_\_

### PART 2: PHYSICAL EXAMINATION REPORT

To the examining physician: Please complete and sign this physical examination report.

Height (ft-in): \_\_\_\_\_ Weight (lbs.): \_\_\_\_\_ Pulse: \_\_\_\_\_ Resp.: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_ Vision: R \_\_\_\_\_ L \_\_\_\_\_

The physical examination of the student revealed the following abnormalities or concerns:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

This student may:  participate fully in school activities including physical education class and/or NJROTC  
 NOT participate fully in the school activities. He has the following restrictions/adaptations: \_\_\_\_\_

This student may:  participate fully in interscholastic athletics and sports teams.  
 NOT participate fully in interscholastic athletics and sports teams. He is restricted from the initialed sports below:  
 Baseball: \_\_\_\_\_ Basketball: \_\_\_\_\_ Cross Country: \_\_\_\_\_ Football: \_\_\_\_\_ Golf: \_\_\_\_\_ Paddling: \_\_\_\_\_  
 Rugby: \_\_\_\_\_ Soccer: \_\_\_\_\_ Track & Field: \_\_\_\_\_ Tennis: \_\_\_\_\_ Volleyball: \_\_\_\_\_ Wrestling: \_\_\_\_\_

Signature of Licensed Examiner \_\_\_\_\_

Print Name of Examiner \_\_\_\_\_

Clinic \_\_\_\_\_

Date \_\_\_\_\_

**Required for Wrestlers Only (must be completed by a physician):**

Current Weight (lbs.): \_\_\_\_\_ Safe Weight Range for Student to Wrestle (lbs. he can safely loss or gain): \_\_\_\_\_

Physician's Signature \_\_\_\_\_

Print Name \_\_\_\_\_

Date \_\_\_\_\_