

**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: \_\_\_\_\_

**THIS SIDE TO BE COMPLETED BY PHYSICIAN**

**STUDENTS NAME (PLEASE PRINT)** \_\_\_\_\_

<b>RELEVANT HEALTH INFORMATION</b>	<b>PHYSICAL ASSESSMENT</b>	<b>NORMAL</b>	<b>ABNORMAL</b>	<b>NOT EXAMINED</b>
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:

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PATIENT HEALTH HISTORY, FINDINGS AND RECOMMENDATIONS:

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PHYSICAL ACTIVITY: RESTRICTED OR UNRESTRICTED – EXPLANATION:

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**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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