6.4A

RETURN TO ATHLETIC DIRECTOR

William S. Hart Union High School District

CERTIFICATE OF PHYSICAL EXAMINATION

Name_____ DOB____/____/____

Height_____ Weight_____ Pulse_____ BP_____/_____

Please place a "✔" as either Normal or Abnormal for all findings below. Please describe in detail all abnormal findings.

	Normal	Abnormal	Comments
Heart			
Pulses			
Lungs			
Neck			
Back			
Shoulder/Arm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle/Foot			
Other pertinent medical findings			

Additional comments:_____

_____

_____

List any restrictions and duration:_____

_____

I hereby certify that _____ was examined by me on_____ 20____

and found to be physically fit to engage in athletics.

Physician's Signature_____ **Date**_____

Stamp name or attach card of medical office here ▼

Back side to be completed by parent/guardian before physical exam.

6.4B

RETURN TO ATHLETIC DIRECTOR

William S. Hart Union High School District

MEDICAL HISTORY TO BE COMPLETED BY PARENT/GUARDIAN BEFORE PHYSICAL EXAM

Name of Student-Athlete_____Sex_____Age_____DOB_____

Grad. Yr._____School_____Sport(s)_____

Year of high school graduation i.e. "2020"

Check **Yes** or **No** (If "Yes" explain)

1. Has the student-athlete had a medical illness or injury since his/her last check up or sport physical? Y ☐ N ☐

2. Is the student-athlete currently taking any prescription or nonprescription (over-the-counter) medication or using an inhaler? Y ☐ N ☐

3. Does the student-athlete have any allergies (for example, pollen, medicine, food, or stinging insects)? Y ☐ N ☐

4. Has the student-athlete ever had a seizure? Y ☐ N ☐

5. Has the student-athlete ever become ill from exercising in the heat? Y ☐ N ☐

6. Is there any pertinent medical information coaches or physicians should know about the student-athlete? Y ☐ N ☐

7. Does the student-athlete wear glasses, contacts, or dental braces? Y ☐ N ☐

Parent/Guardian Signature _____ **Date** _____