

William S. Hart Union High School District  
**MEDICAL HISTORY**  
**TO BE COMPLETED BY PARENT/GUARDIAN**  
**BEFORE PHYSICIAN'S PHYSICAL EXAM**

*A medical history completed by the parents and a physician's verification that the student is healthy enough to participate in sport training and competition must be completed prior to the start of practice.*

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Grade \_\_\_\_\_ School \_\_\_\_\_ Sport \_\_\_\_\_

Please circle "Y" for yes, and "N" for no. (If yes, please 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 non-prescription (over-the-counter) medication, or using an inhaler? Y N

3. Does the student-athlete have any allergies? (pollen, medicine, food, stinging insects, etc.) 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 that coaches or physicians should know about this student- athlete? Y N

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

**ALL PHYSICALS WILL BE DEEMED TO EXPIRE IN JUNE OF THE CURRENT SCHOOL YEAR AND WILL NEED TO BE RENEWED FOR SUMMER PROGRAM PARTICIPATION!**

***Please sign indicating you have read and understand ALL the information/clearances stated at [www.canyonhighcowboys.org](http://www.canyonhighcowboys.org) . These forms MUST be completed online and a completed Athletic Physical and Medical History Form MUST be returned to ASB for an athlete to be cleared for participation.***

Student-Athlete's signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian's signature \_\_\_\_\_ Date \_\_\_\_\_

William S. Hart Union High School District  
2017-18  
**CERTIFICATE OF PHYSICAL EXAMINATION**

**Must be completed by a Licensed Physician (M.D.)**

*Due to new district guidelines, physicals can no longer be completed by a Chiropractor.*

Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_/\_\_\_\_

Please put 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 the above-named student was examined by me on \_\_\_\_\_ (date) and found to be physically fit to engage in athletics.

Physician's signature \_\_\_\_\_

Stamp name or attach card of medical office here

