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

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

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

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

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

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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 . 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
2018-19
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