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STUDENT ATHLETIC PARTICIPATION & PHYSICAL EXAM FORM

PLEASE PRINT. This section must be completed by student and parent/guardian prior to physical examination.

Student Name _____ Birth Date _____ Sex: M / F Grade

Student Address _____ OH _____
Street City Zip

Parent/Guardian Name _____ Parent Phone _____

Address (if different than student) _____

Family Physician Name & Phone: _____

Student's Medical History

Yes	No		
____	____	1.	Have you ever been hospitalized, had surgery, injury or serious medical illness?
____	____	2.	Are you now under the care of a physician or taking any medication?
____	____	3.	Do you have any known allergies?
____	____	4.	Do you use an inhaler?
____	____	5.	Have you ever blacked out, lost consciousness, become dizzy, etc. during physical activity?
____	____	6.	Are you required to use any special protective/corrective devices for sports (knee brace, retainer, etc.)?
____	____	7.	If you wear glasses or contacts, please circle one: glasses contacts
		8.	Date of last tetanus shot:

If yes to any of the above questions, please explain; or you may write any other comments.

We consent to the participation of the above-named student in school sports, including practice and travel to/from activity. We also agree to emergency medical treatment as deemed necessary by physician (every effort will be made to contact parent).

_____ _____
Parent/Guardian Signature **Date**

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PHYSICAL EXAMINATION (To be completed by physician)

Height _____ Weight _____ Pulse _____ BP _____ / _____ Heart: _____

Eyes/Ears/Nose/Throat: Normal / Abnormal Reflexes: Normal / Abnormal Lungs: _____

Abnormal Findings (including infectious, contagious or cardiovascular disease):

Should there be any limitations placed? No ____ Yes ____ (Explanation/Recommendation)

I certify that I have on this date examined this student and that, on the basis of the examination requested by the school authorities and the student's medical history as furnished to me, I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities (note exceptions above).

_____ _____ _____
Physician's printed name (or stamp) **Physician's signature** **Date**