

PHYSICAL EXAMINATION FORM AND SPORTS CANDIDATE FORM

NAME: _____ DOB: _____ GRADE: _____ SPORT: _____

PAST HEALTH HISTORY(Provide dates): Current Medications:

Asthma: _____ Diabetes: _____ Cardiac: _____ Chicken Pox: _____ Pneumonia: _____
 Mononucleosis: _____ Seizure Disorder: _____ Allergies: _____ Fifth Disease: _____
 Lyme Disease: _____ Fractures/Dislocations: _____ Sprains: _____ Other: _____
 Head Trauma/Concussion & Grade: _____ Hospitalization/Surgery: _____

IMMUNIZATION RECORD: (MUST BE COMPLETED BY PHYSICIAN-provide mm/dd/yy):

DTaP: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ DT: _____ TdaP: _____
 Polio: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ Varicella/Varivax: 1. _____ 2. _____
 MMR: 1. _____ 2. _____ Measles: 1. _____ 2. _____ Mumps: _____ Rubella: _____
 Hib: 1. _____ 2. _____ 3. _____ 4. _____ PCV/Prevnar: 1. _____ 2. _____ 3. _____ 4. _____
 HEP B: 1. _____ 2. _____ 3. _____ HEP A: 1. _____ 2. _____ Menactra/Menomune: _____
 HPV/Gardasil: 1. _____ 2. _____ 3. _____ Rotavirus: _____ Other: _____
 TB/PPD: _____ Result: _____ CXR/Result: _____ BCG: _____

PHYSICAL EDUCATION PARTICIPATION: FULL: _____ LIMITED: _____ NONE: _____
 Explain If Limited Or None: _____

FOR INTERSCHOLASTIC COMPETITIVE SPORTS – MUST BE COMPLETED BY A PHYSICIAN:

This certifies that the above named student is physically qualified to participate in the following categories of competition during the current school year.

<u>Contact/Collision</u>	<u>Limited Contact/Impact</u>	<u>Strenuous Noncontact</u>	<u>Nonstrenuous Noncontact</u>
{ } Yes { } No	{ } Yes { } No	{ } Yes { } No	{ } Yes { } No
Football	Baseball, Basketball	Cross Country	Bowling
Lacrosse	Cheerleading, Diving	Badminton	Golf
Soccer	Gymnastics, Handball	Swimming, Tennis	
Wrestling	Kickline, Softball	Track & Field	
	Volleyball	Winter Track	

SCHOOL HEALTH HISTORY: Student carries: { } EPIPEN { } INHALER { } INSULIN PUMP
 Other: _____

HEALTH EXAMINATION (*ACTUAL READINGS REQUIRED): WNL = Within Normal Limits

*Height _____ *Weight _____ *BMI _____ *Blood Pressure _____ *Pulse _____
 Neurological: _____ GI: _____
 Eyes(with/without correction): (R) _____ (L) _____ GU: _____
 Ears/Nose/Throat: _____ Skin: _____
 Mouth/Teeth: _____ Orthopedic: _____
 Cardiac: _____ Scoliosis: _____
 Pulmonary: _____ Nutrition: _____

Reason for Disqualification, if any: _____

PE Date _____ Physician's Signature _____ Phone _____ STAMP: _____