PHYSICAL FORM

PHYSICAL EXAMINATION

MEDICAL INFORMATION

Participant Name:	Age:	Grade:	Sex: M or F
Physician Name:	Home #:	Work #:	

PATIENT HEALTH HISTORY			***TO BE COMPLETED BY PHYSICIAN***				
Parents or guardian, please answer yes or no to the following questions			**Vitals**	**Satisfactory**		**Exam Comments**	**Follow Up**
	Yes	**No**		**Yes**	**No**		
Chronic or Recurrent Illness			Height				
Hospitalization			Weight				
Operations			BP				
Taking Medication			Pulse				
Organs Missing			General:				
Heat Exhaustion			Head				
Dizziness, Fainting, Seizures			Eyes				
Knocked Out			Ent				
Wear Glasses / Contacts			Dental				
Hearing Problems			Chest				
Allergic to Medication			Heart				
High Blood Pressure			Abdomen				
Bone, Joint, Spine Injury			Genitalia				
Liver, Spleen, Kidney or Skin Problems			Skin				
Experienced any heart related problems?			Extrem, Back, Neck				
Is the participant currently taking any medications? If so, list:			Comments:				

	The above information is correct to the best of my knowledge. I hereby give my informed consent for the above mentioned student to participate in activities. I understand the risk of injury in athletic participation.	Sports Participation approved: _____Yes _____ No ____ Deferred
	X	**X**
	Signature of Parent or Guardian / Date	Signature of Physician / Date