

Physical

Name: _____ Age: _____ DOB: _____

School: _____

Height: _____ Weight: _____ BP: _____

Rt Eye: _____ Lt Eye: _____ Pulse: _____

Pupils Equal: Yes _____ No _____

Satisfactory:	Yes	No
General		
Head		
ENT		
Chest		
Heart		
Abdomen		
Skin		
Extremities/Back/ Neck		

MARK YES OR NO ONLY	YES	NO
Chronic/Recurrent Illness?		
Hospitalization?		
Surgery other than tonsils?		
Injuries treated by physician?		
Current medications?		
Organs missing?		
Heat exhaustion/stroke?		
Dizziness, fainting, convulsions and or headaches?		
Knocked out?		
Concussion?		
Wear glasses or contacts?		
Hearing defects?		
Dental appliances- bridge, braces, cap or plate?		
Cough/pain?		
Problems with blood pressure or heart murmurs?		
Problems with liver, spleen or kidney?		
Hernia?		
Recurrent skin disease?		
Bone/joint injury? Sprain/dislocation? Injury that caused a missed event?		
Allergy to medications?		
Tetanus Booster in the last 10 years?		

_____ Passed with no restrictions.

_____ Passed with restrictions. Further
evaluation should be received for the
following reasons: _____

_____ Failed. Due to: _____

Provider Signature _____ Date _____

I hereby give my consent for the above named student to receive a physical for athletic activities.

Parent/Guardian Signature _____ Date _____