*Please complete the highlighted sections ONLY!

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____________