

Physical Examination

Student's Full Name _____ (Please Print)

Date of Birth _____

Age _____

Date of Examination: _____ *Physicals are good for 2 years from exam date.*

Parent Name(S): _____
(Please Print)

1. Have you had a medical problem, illness or injury since your last exam?	YES	NO
2. Are you presently taking ANY medications (including vitamins, aspirin, non-prescription or prescription meds.)	YES	NO
3. Do you have ANY allergies (medicines, bees, food, or other)?	YES	NO
4. Have you ever had chest pains, dizziness, fainting, or passing out during or after exercise?	YES	NO
5. Have any close relatives had heart problems, heart attack, or sudden death before they were age 50?	YES	NO
6. Have you ever had fainting, convulsions, seizures or sever dizziness?	YES	NO
7. Do you wear eyeglasses, contact lenses or protective eye wear?	YES	NO
8. Do you wear any dental appliance such as braces, bridge, plate, or retainer?	YES	NO
9. Must you use special equipment for competition (pads, braces, etc.)?	YES	NO

Please give a brief explanation of any questions answered with a "yes" below.

To be complete by physician:

Physician: _____
(Please Print)

This student is able to fully participate in any of the following supervised interscholastic sports:

Fall: Soccer / Volleyball

Winter: Basketball

Spring: Track / Softball

Yes No With restrictions / limitations as noted below.

The above named student may participate in the approved activities listed above with following limitations:

Signature of the Physician

Date