STUDENT HEALTH HISTORY - Student Name _____

TO BE FILLED OUT BY PARENT PRIOR TO PHYSICAL

Has your child ever had / now have:

YES	NO			YES	NO
		Allergies	Heart Trouble		
		Anemia	Heart Dysfunction		
		Arthritis	Hepatitus		
		Asthma	Hernia		
		Concussion	Kidney Trouble		
		Diabetes	Migraine Headaches		
		Epilepsy (siezure)	Mononucleosis		
		Fainting	Rheumatic Fever		
			Valley Fever		

Is student now under Dr. Care? _____

Why? _____

Family Physician: _____

Phone: _____

Medications now taking: _____

_____

Allergies, including medications: _____

_____

Past surgeries: _____

Dates: _____

Past fractures: _____

Dates: _____

TO BE COMPLETED BY PHYSICIAN

Height _____

Weight _____

Vision:

R 20/ _____

L 20/ _____

Wears:

Glasses _____

Contacts _____

Urinalysis:

Albumin _____

Sugar _____

Blood _____

Heart _____

Lungs _____

Abdomen _____

Genitalia _____

Lymphatics _____

Hernia _____

Other Lab Tests: _____

_____

_____

_____

Skin _____

Nose/Throat _____

Teeth _____

Pulse _____

B/P _____

Hearing R _____ L _____

Spine _____

Neck _____

Joints _____

Reflex:

upper _____

lower _____

Family History:

Diabetes ( )yes ( )no

Heart Disease

( )yes ( )no

Cancer ( )yes ( )no

Date of last TETANUS / DIPTHERIA: _____

I certify that I have, on this date, examined the above named student and found no medical reasons to disqualify him / her from participating in all supervised athletics except:

_____

Physician Name (please print) _____

Physician Signature _____ Date _____

Address _____ Phone _____

ORTHOPEDIC EXAMINATION - OPTIONAL

NECK	WNL	ABNL	KNEES	WNL	ABNL	ANKLE	WNL	ABNL
IMPINGEMENT SIGN	_____	_____	VALGUS	_____	_____	INVERSION STRESS	_____	_____
COMPRESSION TEST	_____	_____	VARUS	_____	_____	EVERSION STRESS	_____	_____
STRENGTH	_____	_____	LACHMAN	_____	_____	TALAR TILT	_____	_____
BACK	_____	_____	PIVOT SHIFT	_____	_____	ANTERIOR DRAWER	_____	_____
SHOULDER	_____	_____	A/P DRAWER	_____	_____	FEET	_____	_____
ELBOW	_____	_____	HAMSTRINGS	_____	_____			
HIPS	_____	_____	RECOMMENDATIONS	_____				

The athlete **may** or **may not** compete in athletics based on the data gathered from this examination.

Physician Signature _____ Date _____

INFORMED CONSENT TO PARTICIPATE:

I/we give our permission for the above athlete to participate in organized interscholastic athletics, realizing that such activity involves the potential for injury which is inherent in all sports. I/we acknowledge that even with the best coaching, use of the most advanced protective equipment, availability of a certified athletic trainer and strict observance of rules, injuries are still a possibility. On rare occasions, the injuries can be so severe as to result in total disability, paralysis, quadriplegia, or even death. I/we acknowledge that I/we have read and understand this warning.