# Elementary District # 12 School Athletic Physical Examination

Name _____ Birthdate _____
Last First M.I.

Address _____ Phone No. _____
Street City Zip

Parent/Guardian _____ Family Physician _____

## Past Medical History

| | | Yes | No | If yes, explain |
|---|---|---|---|---|
| 1. | Presently taking medication? | ___ | ___ | _____ |
| 2. | Allergic to medicine, foods, bee stings? | ___ | ___ | _____ |
| 3. | Wears any appliances--glasses, contact lenses? | ___ | ___ | _____ |
| 4. | History of braces, chipped teeth, bridges? | ___ | ___ | _____ |
| 5. | Has ongoing medical problem? | ___ | ___ | _____ |
| 6. | Had serious or significant illness? | ___ | ___ | _____ |
| 7. | Any past surgical operations, accidents, non-sports or related injuries? | ___ | ___ | _____ |
| 8. | Any past injuries directly related to sports? | ___ | ___ | _____ |
| 9. | Any hospitalizations not explained above? | ___ | ___ | _____ |
| 10. | Any known deformities [such as curvature of back, heart problems, one kidney, blind in one eye, one testicle, etc.]? | ___ | ___ | _____ |
| 11. | Any serious family illness [such as diabetes, heart attack before age 50, bleeding disorders, etc.]? | ___ | ___ | _____ |
| 12. | Any fainting or dizziness while exercising? | ___ | ___ | _____ |
| 13. | Any loss of consciousness, concussion, or head injury? | ___ | ___ | _____ |

I certify that the above information is correct to the best of my knowledge.

Student Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

# Physical Examination

Name_____ Birthdate_____

Height_____ Weight_____ Blood Pressure_____

Pulse [resting]_____ After 15 hops_____ After 2 minutes _____

Examination Date_____ Comments:

HEART: Murmur _____ _____

Rhythm _____ _____

GEN. POSTURE: _____ _____

HERNIA: _____ _____

LUNGS: Percussion _____ _____

Auscultation _____ _____

NOSE & THROAT: _____ _____

ORTHOPEDIC: Feet _____ _____

Knees _____ _____

Shoulders _____ _____

Spine _____ _____

OTHER: _____ _____

_____

RESTRICTIONS _____ _____

_____

Physician's Signature _____

Additional Comments: