

Name _____ Address _____

Home Phone _____ Emergency Phone _____ Age _____ Grade _____ Sex _____

Date of Birth _____ Place of Birth _____

PARENT'S OR GUARDIAN'S NAME

PHYSICIAN'S NAME

CIRCLE THE APPROPRIATE NUMBERS IF YOU HAVE ANY OF THE FOLLOWING:

- | | | |
|---|---|--|
| 1. Drug Allergies
_____ | 11. High Blood Pressure
12. Eye Surgery
13. Chronic Cough
14. Asthma
15. Collapsed Lung
16. Lung Disease
17. Hepatitis
18. Infectious Mono.
19. Peptic Ulcer
20. Appendectomy
21. Hernia
22. Hernia Repair
23. Kidney Trouble | 24. Testicle Operation
25. Broken Bones:
_____ |
| 2. Eye Injury/Disease
3. Ear Surgery
4. Mastoid Surgery
5. Frequent Sore Throat
6. Fainting or Dizzy Spells
7. Convulsions
8. Rheumatic Fever
9. Heart Disease
10. Diabetes | | 26. Back Problem
27. Severe Headaches
28. Head Injuries
29. Neck Injuries
30. Other Bone or Joint Problems
31. Other: _____ |

PHYSICIAN TO COMPLETE THIS PORTION

Physicians comments on circled items in history section above: _____

B.P. _____ PULSE _____ URINALYSIS: Blood _____ Protein _____ Sugar _____

Circle number if abnormal and explain below:

- | | | | | |
|----------|------------|--------------|------------------|-----------------------|
| 1. HEENT | 4. Lung | 7. Hernia | 10. Pilonidal | 13. Upper Extremities |
| 2. Teeth | 5. Heart | 8. Genitalia | 11. Lymph Glands | 14. Lower Extremities |
| 3. Chest | 6. Abdomen | 9. Skin | 12. Back & Neck | |

Physicians comments on circled items: _____

THE ABOVE STUDENT IS PHYSICALLY ABLE TO PARTICIPATE IN THE CHECKED SPORTS:

- | | | | | |
|------------------|-------------------|----------------|--------------|----------------|
| ___ ALL | ___ Cross Country | ___ Gymnastics | ___ Soccer | ___ Track |
| ___ Baseball | ___ Equestrian | ___ Hockey | ___ Softball | ___ Volleyball |
| ___ Basketball | ___ Football | ___ Pom | ___ Swimming | ___ Wrestling |
| ___ Cheerleading | ___ Golf | ___ Skiing | ___ Tennis | |

DATE _____ SIGNED _____

(Physician's Signature)