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

   _____

   _____
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
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:

    _____

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

Physicians comments on circled items: _____

_____

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

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

DATE _____ SIGNED _____

(Physician's Signature)