



Physical Form

Student's Name _____ Birth Date _____
Mo./Day/Year

Age _____ Grade _____ Sex _____ Place of Birth _____
(County/City/State)

Parent's Name _____ Telephone _____

Home Address of Student _____
(Street or RFD Number) (City) (Zip Code)

History of: (Circle One)

- 1. Any injuries requiring medical attention Yes No
- 2. Any illness lasting more than one week Yes No
- 3. Being under a physician's care at this time Yes No
- 4. Taking any medicine prescribed by a physician Yes No
(regularly or not)
- 5. Wear glasses or contact lenses Yes No
- 6. A surgical operation or fracture Yes No
- 7. Being in a hospital (except tonsillectomy) Yes No
- 8. Any reason(s) known by anyone why this individual should Yes No
not participate in any or all sports
- 9. Any known allergies Yes No
- 10. Any chronic disease Yes No
- 11. Suitable inoculations and boosters - Tetanus (booster every Yes No
5 years), poliomyelitis, influenza
- 12. Any special reason to omit strenuous exercises Yes No

If yes to any of the reasons stated, list number and specify any or all abnormalities below:

TO BE COMPLETED BY PHYSICIAN

Name of Student _____ City and School _____
Age _____ Height _____ Weight _____ lbs. Blood Pressure _____ Pul _____ Res _____
Eyes _____ R20/_____, Lt20/_____; Ears _____ Hearing R_____/15, Lt_____/15

Significant past illness or injury _____

Cardiovascular _____

Respiratory _____

Liver _____ Spleen _____ Hernia _____

Musculoskeletal _____ Skin _____

Neurological _____ Genitalia _____

Laboratory: Urinalysis _____ Other _____

Comments on specific abnormalities, previous surgery and scars _____

I certify that on this date I examined this student and on the basis of this examination, along with the medical history furnished to me, I found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities.

Signature of Licensed Physician _____ M.D. _____ O.D. _____

Physician's Address _____ Telephone _____

Date _____