

**PART I - MEDICAL EVALUATION OF STUDENT FOR PARTICIPATION IN PHYSICAL EDUCATION AND SPORTS**

To be completed by Parent or Guardian and submitted to the examining physician **before** he examines the student.

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Grade: \_\_\_\_\_  
 Last First Middle

Name of Parent(s): \_\_\_\_\_ Home Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

PERSONAL HEALTH OF STUDENT (Check correct reply)

	YES	NO		YES	NO
1. Has had injuries or accidents requiring medical attention	<input type="checkbox"/>	<input type="checkbox"/>	9. Has up to date immunization	<input type="checkbox"/>	<input type="checkbox"/>
2. Has had a surgical operation	<input type="checkbox"/>	<input type="checkbox"/>	10. Has had tetanus toxoid and booster inoculation	<input type="checkbox"/>	<input type="checkbox"/>
3. Has been in a hospital	<input type="checkbox"/>	<input type="checkbox"/>	11. Has seen a dentist within the past 6 months	<input type="checkbox"/>	<input type="checkbox"/>
4. Has had sickness lasting longer than one week	<input type="checkbox"/>	<input type="checkbox"/>	12. To my knowledge the paired organs that follow are present and healthy:	<input type="checkbox"/>	<input type="checkbox"/>
5. Takes medicine now or regularly	<input type="checkbox"/>	<input type="checkbox"/>	Eyes	<input type="checkbox"/>	<input type="checkbox"/>
6. Has a condition now under a physician's care	<input type="checkbox"/>	<input type="checkbox"/>	Ears (hearing)	<input type="checkbox"/>	<input type="checkbox"/>
7. Has a defect in hearing or eyesight (glasses, contact lenses)	<input type="checkbox"/>	<input type="checkbox"/>	Kidneys	<input type="checkbox"/>	<input type="checkbox"/>
8. Is there any reason this student should not take part in any sport or physical activity?	<input type="checkbox"/>	<input type="checkbox"/>	Testicles or Ovaries	<input type="checkbox"/>	<input type="checkbox"/>
			Arms/Legs	<input type="checkbox"/>	<input type="checkbox"/>
			Fingers/Toes	<input type="checkbox"/>	<input type="checkbox"/>

If you answered "YES" to any of the above questions, explain here with the names and dates:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

If you answered "NO" to any of the above questions, explain here with names and dates:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I hereby give consent for the above school student to engage in sports activities as a representative of his school, and to participate fully in Physical Education class, except those activities crossed out by the examining physician on the reverse side of this form. I also give my consent for the above student to accompany the team as a member for its "away" games and contests.

I GIVE MY PERMISSION FOR THE PHYSICIAN TO COMPLETE PART II FOR CONFIDENTIAL USE IN MEETING MY CHILD'S HEALTH AND EDUCATIONAL NEEDS IN SCHOOL.

\_\_\_\_\_  
 Signature of Parent or Guardian

\_\_\_\_\_  
 Date

**PART II - MEDICAL EVALUATION OF STUDENT FOR PARTICIPATION IN PHYSICAL EDUCATION AND SPORTS**

(To be completed by a physician or under his supervision)

Name of Student: \_\_\_\_\_ Grade: \_\_\_\_\_  
 Last First Middle

Significant past illnesses or injuries \_\_\_\_\_

**PHYSICIAN'S EXAMINATION:** (Circle and explain abnormal findings)

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Pulse Rate \_\_\_\_\_  
 Eyes \_\_\_\_\_ Visual Activity / /  
 Ears \_\_\_\_\_ Hearing / /  
 Nose (deformities) \_\_\_\_\_ Oropharynx \_\_\_\_\_  
 Teeth (cavities, denture, braces) \_\_\_\_\_ Cardiovascular (pedal pulses) \_\_\_\_\_  
 Breasts (M&F) \_\_\_\_\_ Respiratory \_\_\_\_\_  
 Abdomen (hernia, spleen, liver) \_\_\_\_\_ Genitalia and anus \_\_\_\_\_  
 Neuromuscular \_\_\_\_\_ Skin \_\_\_\_\_  
 Spine \_\_\_\_\_  
 Scoliosis Screening \_\_\_\_\_

**Laboratory:**  
 Urinalysis: Protein \_\_\_\_\_  
 Sugar \_\_\_\_\_  
 Other \_\_\_\_\_  
 \* Tuberculin Test \_\_\_\_\_  
 \* Chest X-Ray (result/date) \_\_\_\_\_  
 \* Other Laboratory Tests \_\_\_\_\_  
 \* if ordered by physician

Extremities (special attention to knees, ankles) \_\_\_\_\_  
 Additional explanations of abnormal findings: \_\_\_\_\_

I have on this date personally examined this pupil, reviewed the history and other data recorded on both sides of this form, and find this pupil physically able to compete in supervised activities listed below which are NOT CROSSED OUT:

- Basketball
- Golf
- Tennis
- Field Hockey
- Cardiovascular Endurance
- Cross Country
- Lacrosse
- Volleyball
- Soccer
- Resistance Training

Other \_\_\_\_\_

\_\_\_\_\_, M.D. \_\_\_\_\_  
 Physician's Signature Physician's Address Physician's Telephone

\_\_\_\_\_, M.D. \_\_\_\_\_  
 Physician's Name Typed Date of Examination