2018/2019 HIGH SCHOOL PHYSICAL SCREENING
**Physical must be dated June 1, 2018 or later** NO EXCEPTIONS

**HISTORY** (Must be completed and signed by parent prior to examination):
SPORT: _______________  SCHOOL: NORTH HIGH  DATE: __________

PRINT  Last Name  First Name  M.I.  Grade  Age  Date of Birth

Address  City  Zip Code

**HEALTH HISTORY** (To be completed by student or parent):
Check and give as much information as possible  Y = yes, N = no
____Heart Trouble  ____High Blood Pressure  ____Asthma  ____Diabetes
____Kidney Problems  ____Head Trauma  ____Seizures  ____Other (List below)

History of any previous injuries, fractures, serious illnesses or operations (Give year of problem)

Current medications  Allergies  Last Tetanus Immunization

**Signature of Parent or Guardian:** ____________________________

**PHYSICAL EXAMINATION** (To be completed by physician):
Height: _______Weight: _______Temp: _______Blood Pressure: _______Pulse: _______Respirations: _______
Visual Acuity: O.D. ___/___ O.S. ___/___ ( ) Corrected ( ) Uncorrected  L.M.P. __________
( ) Chest Pain ( ) Extreme S.O.B. ( ) Dizziness ( ) Fatigue ( ) Palpitations ( ) Sudden Death of Family Member

<table>
<thead>
<tr>
<th>10. MUSCULOSKELETAL, ROM, STRENGTH</th>
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<tbody>
<tr>
<td>NORMAL</td>
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<tr>
<td>________________</td>
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<tr>
<td>2. EARS, NOSE, THROAT</td>
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<td>4. NECK</td>
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<td>5. CARDIOVASCULAR</td>
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<td>6. CHEST AND LUNGS</td>
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<td>7. ABDOMEN</td>
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<td>9. GENITALIA-HERNIA(MALE)</td>
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**ABNORMAL FINDING:** ______________________________________

**RECOMMEND:** ( ) Full Activity, No Restrictions
( ) Activity with Restrictions: ( ) No contact sports  ( ) Other: ____________
( ) No Participation

**EXAMINING PHYSICIAN:** Name_________________________ License#: __________ Date: __________
Address: ____________________________  Doctor’s Stamp here: ____________________________
Phone #: __________  Date of Exam: __________