

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
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Signature of Parent or Guardian: _____

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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

	NORMAL	10. MUSCULOSKELETAL, ROM, STRENGTH	
1. EYES		NECK	
2. EARS, NOSE, THROAT		SPINE	
3. MOUTH AND TEETH		SHOULDERS	
4. NECK		ARMS/HANDS	
5. CARDIOVASCULAR		HIPS	
6. CHEST AND LUNGS		THIGHS	
7. ABDOMEN		KNEES	
8. SKIN		ANKLES	
9. GENITALIA-HERNIA(MALE)		FEET	
		11. NEUROMUSCULAR	

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: _____