

# 2019/2020 HIGH SCHOOL PHYSICAL SCREENING

**\*\*Physical must be dated June 1, 2019 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

	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:** \_\_\_\_\_