

2020/2021 HIGH SCHOOL PHYSICAL SCREENING

****Physical must be dated June 1, 2020 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: _____

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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

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