

STUDENT HEALTH HISTORY

A. GENERAL HISTORY. Check an answer for each item

YES NO

- 1. Diabetes
- 2. Seizures
- 3. Dizziness
- 4. Bleeding disorders
- 5. Asthma, allergies
- 6. Heart Disease
- 7. Hearing problems
- 8. Taking medication (type, reason, dosage)
- 9. Any allergic reactions
- 10. Have you ever been hospitalized?

YES NO

- 11. High or low blood pressure
- 12. Hernia
- 13. Absence of a kidney
- 14. Absence of or, undescended testicle
- 15. Absence of any organ
- 16. Menstrual Disorder
- 17. Under physician's care at present
- 18. Loss of consciousness
- 19. Change in health during the past year
- 20. Give date of last tetanus shot _____

Details of any answers

B. ORTHOPEDIC HISTORY: If the student has had, or now has, any of the following areas injured please give details:

1. Shoulder, arm, elbow, wrist, fingers, or thumb injury: type/when? _____
2. Hip, knee, leg, calf, ankle, foot, or toe injury: type/when? _____
3. Head, neck, or spine injury: type/when? _____

Family Doctor: _____

I/we verify that the above information is correct and I give permission for my child to receive a physical examination.

Date: _____	Parent/Guardian signature: _____	Phone#: _____
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STUDENT ATHLETE PHYSICAL EXAMINATION

Student: _____

A. PRE-PHYSICAL

Height: _____ Weight: _____ Blood pressure: _____ Vision: Right _____ Left _____

Dental: Braces _____ Broken or missing teeth _____ Plates _____ Glasses: YES NO _____ Anisocoria: YES NO _____
(unequal pupils)

B. GENERAL PHYSICAL

Heart _____ Lungs _____ Abdomen _____

Hernia _____ Varicocele _____

C. ORTHOPEDIC EVALUATION

C Spine _____ T Spine _____ L Spine _____

Hips/pelvis _____ Knees _____ Feet/ankles/toes _____

Shoulders _____ Elbows _____ Wrists/hands/fingers _____

- *****
- Approved for athletic competition
 - Disapproved for athletic competition, state reason _____
 - Approved for athletic competition, refer to specialist for _____
 - Disapproved for athletic competition, refer to specialist for _____

DATE OF PHYSICAL _____	PRINT NAME OF PHYSICIAN _____	SIGNATURE OF PHYSICIAN _____
MEDICAL LICENSE # _____	PHONE # OF PHYSICIAN _____	ADDRESS OF PHYSICIAN _____