

Athletic Physical

Name	Date of Birth
Grade	Date of Exam
Intended Sports	

<u>Current</u>
Medical Problems
Medications 1. _____ 2. _____ 3. _____

<u>History</u>
Previous head injury
Previous seizures
Previous broken bones
Previous surgeries 1. _____ 2. _____

Parent Signature \_\_\_\_\_

Date \_\_\_\_\_

The following is to be filled out by the patient's physician:

<u>Physical</u>			
Height	Weight	BP	Pulse
Eyes			
Ears			
Lungs			
Heart			
Abdomen			
Hernia (males)			
Musculoskeletal (scoliosis, joints, strength)			

Based on medical history and physical exams, this student is approved for participation in sports activities for the current school year.

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date