

(Information on this form may be shared with appropriate personnel for health and educational purposes.) Please Print Information Clearly

Student's Name: (Last First Middle)			Birth Date: (Month Day Year)		Sex	Grade Level	ID #
Address			City		Zip		Parent/Guardian
					Home Phone:		Work Phone:

Health History: To Be Completed by Parent/Guardian <input checked="" type="checkbox"/> all that apply to your Child or your immediate Family	Student		Family		Comments
	No	Yes	No	Yes	
Asthma					
Blood Disorders: e.g. Hemophilia, Sickle Cell, Hepatitis					
Blood Pressure (High or Low)					
Birth Defects					
Bone/Joint Problems/Injury					
Developmental Delay					
Diabetes					
Dizziness or Chest Pain with Exercise					
Ear/Hearing Problems					
Head Injury/Concussion/Passed Out					Date: _____
Heart Problem/Heart Murmur/Shortness of Breath					
Scoliosis					
Seizures					If Yes, What are they like?
Wheeze/Cough During or After Play					Indicate Severity:
Tobacco Use (Type, Frequency)					
Alcohol/Drug Use					
Family History of Sudden Death before Age 50					Cause: _____
Serious Injury or Illness					

Chickenpox? Year of disease or date of Vaccine: _____ No Yes Loss of Function of One of Paired Organs? (Eye/Ear/Kidney/Testicle)

Last Tetanus Shot Date: _____ Hepatitis B Series (give dates): #1 _____ #2 _____ #3 _____

Eye/Vision: <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts Other Concerns? Last Exam: _____	Hospitalizations, Surgery: (List All) When? What For? _____
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Dental/Oral: <input type="checkbox"/> Braces <input type="checkbox"/> Retainer <input type="checkbox"/> Bridge <input type="checkbox"/> Plate Other Concerns? Last Exam _____	Emotional/Behavioral Disorders: <input type="checkbox"/> ADHD <input type="checkbox"/> ADD <input type="checkbox"/> Anorexia <input type="checkbox"/> Bulimia <input type="checkbox"/> Bi Polar <input type="checkbox"/> Depression Other Concerns? <input type="checkbox"/> None
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Allergies: (Food, drug, insect, other) <input type="checkbox"/> None	Medications: (List all prescribed or taken on a regular basis.) <input type="checkbox"/> None
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Needs/Modifications: required in the school setting <input type="checkbox"/> None Dietary Needs/Restrictions: <input type="checkbox"/> None	Other Concerns: <input type="checkbox"/> None
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Special Instructions/Devices: e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic supporter/cup

None

Physical Findings: To Be Completed By MD/APN/PA

Optional Tests		Date	Results	Date	Results		
Hemoglobin					Urinalysis		
Hematocrit					Other		
Temp	Pulse	Resp Rate	BP /	Height in	% Height	Weight lbs	% Weight
	Normal	Abnormal	Comments/Follow-up/Needs		Normal	Abnormal	Comments/Follow-up/Needs
Skin				Endocrine			
Ears				Abdomen/GI/Liver			
Eyes				Genito-Urinary			LMP:
Nose				Neurological			
Throat				Musculoskeletal			
Mouth/Dental				Spinal Examination			
Cardiovascular/HTN				Nutritional Status			
Respiratory				Mental Health			

EMERGENCY ACTION needed while at school due to child's health condition (e.g. seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
 No Yes If Yes, please describe:

Other Findings and Comments:

Referral:

Is there anything you would like to discuss about this student's health with school or school health personnel? No Yes

I certify that I have on this date examined this student and that, on the basis of the examination, and the student's medical history as furnished to me, I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities.

Physician/Advanced Practice Nurse/Physician Assistant performing examination

Print Name _____ Signature _____ Date _____

Address: _____ Phone: _____

Emergency Treatment/Surgical Authorization:

In case of an emergency, I hereby authorize any qualified person to administer first aid and any other treatment essential to the health and well being of my son/daughter. In the event that surgery is necessary, I hereby authorize any licensed and qualified surgeon and his/her choice of assistants and anesthetist to perform emergency surgery that is deemed necessary

Insurance Information

Company

ID Number: _____ Group Number: _____

Parent/Guardian Signature _____ Date _____

Coach's Information

I have inspected the completed Physical Form, Medical History, and Parent Consent Form. The student athletes and parent/guardian have completed all of the pertinent information.

Coach's Signature _____ Date _____