

PHYSICAL EXAMINATION REPORT

STUDENT'S NAME _____

(last)

(first)

(middle initial)

(phone)

(address)

(city)

(state) (zip)

Date of Birth _____

Sex _____

Grade level in Sept. _____

Mother's Name _____

Father's Name _____

Address _____

Address _____

Phone _____

Phone _____

Student's Medical History

(to be completed by parent/guardian or physician)

	Yes	No	Date	Description/Reason
Allergies	<input type="checkbox"/>	<input type="checkbox"/>		
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		
Blood Disorders	<input type="checkbox"/>	<input type="checkbox"/>		
Cancer	<input type="checkbox"/>	<input type="checkbox"/>		
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		
Headaches	<input type="checkbox"/>	<input type="checkbox"/>		
Hearing Problem/Hearing Aid	<input type="checkbox"/>	<input type="checkbox"/>		
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>		
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>		
High/Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>		
Hospitalizations	<input type="checkbox"/>	<input type="checkbox"/>		
Kidney/Urinary Tract Problem	<input type="checkbox"/>	<input type="checkbox"/>		
Medication Reactions	<input type="checkbox"/>	<input type="checkbox"/>		
Menstrual Disorder	<input type="checkbox"/>	<input type="checkbox"/>		
Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>		
Muscular Disorder	<input type="checkbox"/>	<input type="checkbox"/>		
Orthopedic Disorder	<input type="checkbox"/>	<input type="checkbox"/>		
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>		
Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>		
Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>		
Strep Infections	<input type="checkbox"/>	<input type="checkbox"/>		
Surgery	<input type="checkbox"/>	<input type="checkbox"/>		
Ulcer/Gastrointestinal Disorder	<input type="checkbox"/>	<input type="checkbox"/>		
Visual Problem/Glasses/Contact Lenses	<input type="checkbox"/>	<input type="checkbox"/>		
Other	<input type="checkbox"/>	<input type="checkbox"/>		

Is the student now under the care of a physician? _____

Does the student take any regular medication? Please name medication and dosage below.

Has the student ever been advised by a physician not to play a sport? _____

Are there any other physical or emotional conditions that might bear on this child's abilities or performance?

COMMENTS: _____

Parent/Guardian Signature: _____

Date: _____