

## STUDENT PARTICIPATION AND PHYSICAL EXAM FORM

PLEASE TYPE OR PRINT

STUDENT'S NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ SEX \_\_\_\_\_ GRADE \_\_\_\_\_

CITY \_\_\_\_\_ LAST \_\_\_\_\_ FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_ SCHOOL \_\_\_\_\_ PLACE OF BIRTH \_\_\_\_\_

STUDENT'S ADDRESS \_\_\_\_\_ STREET \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

PARENT(S) NAME \_\_\_\_\_

ADDRESS (IF DIFFERENT THAN STUDENT) \_\_\_\_\_

STREET \_\_\_\_\_ HOME TELEPHONE NO. \_\_\_\_\_

CITY \_\_\_\_\_ ZIP \_\_\_\_\_

FAMILY PHYSICIAN'S NAME, ADDRESS, PHONE NUMBER \_\_\_\_\_

### ATHELETE'S HISTORY

YES

NO

- HAS THIS ATHLETE EVER HAD HOSPITALIZATION, SURGERY, INJURY, OR SERIOUS MEDICAL ILLNESS? . . . . . \_\_\_\_\_
- IS THIS ATHLETE NOW UNDER THE CARE OF A PHYSICIAN OR TAKING ANY MEDICATION? . . . . . \_\_\_\_\_
- HAS ANY PHYSICIAN EVER RECOMMENDED OR DO YOU FEEL THAT THERE SHOULD BE LIMITS PLACED ON PARTICIPATION IN COMPETITIVE SPORTS? . . . . . \_\_\_\_\_
- DOES THIS ATHLETE HAVE ANY KNOWN ALLERGIES TO MEDICATIONS? . . . . . \_\_\_\_\_
- DOES THIS ATHLETE WEAR GLASSES OR CONTACT LENSES? GIVE DATE OF LAST EXAM IF "YES" . . . . . \_\_\_\_\_
- HAS THIS ATHLETE EVER BLACKED OUR OR LOST CONSCIOUSNESS DURING PHYSICAL ACTIVITY? . . . . . \_\_\_\_\_

IF YES, PLEASE SPECIFY

STUDENT \_\_\_\_\_

PARENT \_\_\_\_\_

DATE \_\_\_\_\_

HISTORY AND CONSENT MUST BE COMPLETED PRIOR TO THE PHYSICAL EXAMINATION

### HEALTH EXAMINATION FORM

STUDENT'S NAME \_\_\_\_\_ GRADE \_\_\_\_\_

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ BP \_\_\_\_\_ PULSE \_\_\_\_\_

ABNORMAL PHYSICAL FINDINGS:

#### OPTIONAL TESTS

URINALYSIS \_\_\_\_\_  
 ALBUMIN \_\_\_\_\_  
 SUGAR \_\_\_\_\_  
 MICRO (IF ABOVE TEST ABNORMAL) \_\_\_\_\_

BLOOD COUNT  
 (FOR FEMALES)  
 HGB \_\_\_\_\_  
 OR  
 HCT \_\_\_\_\_

SHOULD THERE BE ANY LIMITATIONS PLACED ON ATHLETIC PARTICIPATION? . . . . . YES \_\_\_\_\_ NO \_\_\_\_\_

RECOMMENDATIONS:

I certify that I have on this date examined this student and that, on the basis of the examination requested by the L.Y.F. authorities 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. (NOTE EXCEPTIONS ABOVE)

PHYSICIAN'S AND ADDRESS (STAMP OR PRINT) \_\_\_\_\_  
 SIGNATURE \_\_\_\_\_

PHYSICIAN'S

M. D. or D. O.

NO. \_\_\_\_\_ DATE \_\_\_\_\_

PHISICIAN'S TELEPHONE

(HISTORY AND CONSENT MUST BE COMPLETED PRIOR TO PHYSICAL EXAMINATION)