William S. Hart Union High School District

MEDICAL HISTORY TO BE COMPLETED BY PARENT/GUARDIAN BEFORE PHYSICAL EXAM

Name of Student-Athlete_____Sex____Age____DOB____/____/_____

Grade_____School_____Sport(s)_____

Y or N (Circle Y or N. If "Yes" explain)

1. Has the student-athlete had a medical illness or injury since his/her last check up or sport physical?_____ Y N

_____

2. Is the student-athlete currently taking any prescription or nonprescription (over-the-counter) medication or using an inhaler? Y N

_____

3. Does the student-athlete have any allergies (for example, pollen, medicine, food, or stinging insects)?_____Y N

_____

4. Has the student-athlete ever had a seizure?_____Y N

5. Has the student-athlete ever become ill from exercising in the heat?_____Y N

6. Is there any pertinent medical information coaches or physicians should know about the student-athlete?_____Y N

_____

7. Does the student-athlete wear glasses, contacts, or dental braces?_____Y N

_____ _____

Parent/Guardian Signature **Date**

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CERTIFICATE OF PHYSICAL EXAMINATION

Name_____DOB____/____/_____

Height_____Weight_____Pulse_____BP_____/_____

Please place a "✔" as either Normal or Abnormal for all findings below. Please describe in detail all abnormal findings.

	Normal	Abnormal	Comments
Heart			
Pulses			
Lungs			
Neck			
Back			
Shoulder/Arm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle/Foot			
Other pertinent medical findings			

Additional comments:_____

_____

_____

List any restrictions and duration:_____

_____

I hereby certify that _____was examined by me on_____200___

and found to be physically fit to engage in athletics.

Physician's Signature_____**Date**_____

Stamp name or attach card of medical office here ▼