



Annual Sports Physical

Date of Medical Exam: _____ (Valid for 1 year)

Student's Name: _____ Date of Birth: _____ Age: _____

Parent's Name: _____

Physician's Name: _____

Address: _____

Phone: _____

Recent (3 years) Medical History

(must be completed by physician)

Hospitalizations ☐ No ☐ Yes*

Serious illnesses ☐ No ☐ Yes*

Accidents ☐ No ☐ Yes*

Allergies ☐ No ☐ Yes*

Physical Handicaps ☐ No ☐ Yes*

Has it been necessary to limit the applicant's activity?

☐ No ☐ Yes*

Medical conditions requiring continuing use of medications?

☐ No ☐ Yes*

Physical Examination

Height _____ % _____ Weight _____ % _____

Blood Pressure _____

Vision: ☐ Normal ☐ Corrected ☐ Other*

Hearing: ☐ Normal ☐ Corrected ☐ Other*

Any temporary hearing problem? ☐ No ☐ Yes*

Mouth: Any structures which could affect speech?

☐ No ☐ Yes*

Motor Coordination: ☐ Normal ☐ Abnormal*

General Physical Examination: _____

Developmental Assessment: _____

Use this area to note details related to affirmative (yes) answers under Medical History.

Important

Date of most recent tetanus vaccination:

**Please explain in the section provided.*

(Please complete reverse side.)

Physical Evaluation—continued

Childhood Diseases *(please indicate dates where applicable)*

Measles _____ Mumps _____ German Measles _____
Chicken Pox _____ Other: _____

Illnesses *(please indicate dates where applicable)*

Convulsions _____ Diabetes _____ Encephalitis _____
Heart Disease _____ Meningitis _____ Kidney _____
Recurrent Ear Infections _____
Other _____

Developmental and Medication History

Please note any family history of epilepsy or other neurological/emotional disorders:

Please list any medications given for hyperactivity, convulsions, or any disorder of similar nature:

Is the child currently on any other type of medication? ☐ No ☐ Yes, if so please list.

Other

Can applicant participate in athletics and physical education programs? ☐ No ☐ Yes, please state reasons.

Remarks

Physician's Signature: _____ Date: _____