I. Student Information (To be completed by parent/guardian)

PLEASE PRINT

Student Name _____ Sex_____
Last First Middle

Birth Date_____ Grade in Fall_____ Age_____

Address_____

City & Zip_____ Home Phone_____

Is student subject to any of the following conditions:

	YES	NO	EXPLANATION
Epilepsy	____	____	_____
Fainting	____	____	_____
Allergies	____	____	_____
Asthma	____	____	_____
Diabetes	____	____	_____
Heart Disease	____	____	_____
Head Injury, seizures	____	____	_____
Knocked unconscious	____	____	_____
Other	____	____	_____

_____

_____

Medications: _____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct

Parent Signature_____

II. Physical Examination (To be completed by a health professional **after April 15** for school year beginning the following August)

Weight_____ Height_____ Blood Pressure_____

Pulse_____ Resp_____ Vision: OS_____ OD_____

	NORMAL	OTHER
Ears	_____	_____
Nose	_____	_____
Throat	_____	_____
Eyes	_____	_____
Skin	_____	_____
Neck	_____	_____
Chest	_____	_____
Lungs	_____	_____
Heart	_____	_____
Posture	_____	_____
Extermities	_____	_____
Feet	_____	_____
Hernia(males only)	_____	_____
Genitalia(males only)	_____	_____

I have examined the above names student and in my opinion he/she may participate in all school organized athletics except those listed.

Restrictions_____

_____

_____

_____

SIGNATURE of health professional Date

_____

PRINT Name of health professional

Revised May 2011