Athletic Exam & Physical Health Form

Both sides of this form must be completed prior to participation in team sports.

Health and Medical History:

This portion must be completed by a parent or guardian and reviewed by a physician.

Student Name:	**Grade:**	**Gender:** M F

Please explain any YES answer.

YES	NO	**Heart murmur**
YES	NO	**High blood pressure**
YES	NO	**Other heart problems**
YES	NO	**Broken bones**
YES	NO	**Weak joints - ankles, knees**
YES	NO	**Concussion**
YES	NO	**Seizures or epilepsy**
YES	NO	**Asthma**
YES	NO	**Blood disorders such as sickle cell trait, anemia**
YES	NO	**Ever fainted or passed out**
YES	NO	**Ever been hospitalized**
YES	NO	**Ever experienced shortness of breath or chest pain**
YES	NO	**Any illness lasting a week or more (i.e., mononucleosis, etc.)**
YES	NO	**Has any family member had a heart attack, heart problems or sudden death before age 50?**
YES	NO	**Other health problems**
Explain.		

ALLERGIES			**PRESCRIPTIONS**		
YES	NO	**Bee stings**	YES	NO	**Adrenaline**
YES	NO	**Foods**	YES	NO	**Inhaler(s)**
YES	NO	**Medicines**	YES	NO	**Other allergy medicine**
YES	NO	**Other**	YES	NO	**Any other medications taken regularly**
			YES	NO	**Contacts, eyeglasses or retainer**

ASSUMPTION OF RISK

Participation in sports requires an acceptance of risk for injury. Your decision to participate in athletics indicates your acceptance of this risk. Any improper use of equipment, failure to abide by procedures, safety rules, and guidelines could result in serious injury to you or an opponent. **I assume all risks associated with participation and agree to hold the school and its employees harmless from any and all liability and claims whatsoever which may arise as a result of participation in sports.**

Parent/Guardian Signature:	Date:
Athlete's Signature:	Date:

Physical Examination:

This portion must be completed and signed by the examining physician.

Name:		**Gender:** M F	**School:** Laguna Blanca
Height:	**Weight:**	**Birthdate:**	**Grade:**
Blood pressure:	***Pulse/rest:**	***Pulse/exercise:**	***Percent body fat:**
***Vision corrected:**	Left	Right	Both
Vision uncorrected:	Left	Right	Both

***Lab: Urine**	**HCT**
Eyes	**Abdomen**
Ears	**Genitalia/Hernia**
Nose	**Peripheral pulses**
Throat	**Cervical spine/neck**
Teeth	**Back**
Skin	**Shoulders**
Lymphatic	**Arm/elbow/wrist/hand**
Lungs	**Knees/hips**
Heart	**Ankles/feet**

** = If medically indicated*

PARTICIPATION RECOMMENDATION			
I have reviewed the student's health and medical history form and completed the student's physical examination. I make the following recommendations for his/her participation in athletics:			
[ ] Full participation	**[ ] Limited participation**	**[ ] No participation**	**[ ] Needs additional evaluation**
If full participation is not recommended, please provide an explanation & recommendations:			
Any recommendations or concerns:			
[ ] Weight loss or gain			
[ ] Conditioning			
[ ] Other			

PHYSICIAN INFORMATION	
Signature	**Date**
Name (print)	
Address	
City/State/Zip Code	
Telephone	