ST. JOHN'S EPISCOPAL SCHOOL
Athletic Participation Physical Examination
General Student Information

5th – 8th GRADE ONLY

NAME ______________________________ **BIRTHDATE**____________ **GRADE**________
Home Address ______________________________ City____________ Phone____________
Name of Parent/Guardian____
Name of Family Physician ____
Address______________________________ City____________ Phone____________

Health History (to be completed by parent/guardian and reviewed by examining physician)
Please answer the following questions by circling "no" or "yes" and explaining as necessary:

Has this student had a complete physical examination in the past three years? (Excluding for athletic participation)	NO	YES
Has this student ever been disqualified from athletic participation for medical reasons?	NO	YES
Has this student ever had any serious illness? Explain ____________________	NO	YES
Has this student ever been in a hospital for other than surgery? Explain ____________ ____________________	NO	YES
Has this student ever had a surgical operation? Explain ____________________ ____________________	NO	YES
Has this student had an injury of a muscle, bone, joint, ligament, or tendon? Explain ____________________	NO	YES
Is this student taking any regular medication? Explain ____________________	**NO**	**YES**
Has this student ever been unconscious? Explain ____________________	NO	YES

Please indicate the following conditions by circling "no" or "yes" and explaining as necessary:

1. Wears glasses NO YES
2. Wears contact lenses NO YES
3. Any kind of ear problem NO YES
   Explain____________________
4. Dizziness or headaches NO YES
   Explain ____________________
5. Seizures, convulsions or fainting spells. Explain ____________ NO YES
6. Loose, chipped, or false teeth NO YES
   Explain ____________________
7. Heart condition? NO YES
   Explain ____________________
8. Kidney problems or blood in the urine NO YES
   Explain ____________________
9. Allergies____________________ NO YES
10. Emotional problems requiring medical attention. Explain ____________ NO YES
11. Back or neck problems NO YES
    Explain ____________________
12. Yellow jaundice, peptic ulcer, intestinal bleeding, or abdominal pain. NO YES
    Explain ____________________
13. Asthma NO YES
    Medication ____________________

*****OTHER HEALTH ASPECTS THE DOCTOR AND SCHOOL SHOULD BE AWARE OF*****

____

This health history is complete and accurate to the best of my knowledge. I understand medical information will be shared with coaches. I understand parents must be on site to provide and administer any medications needed for sports. Coaches cannot administer any medications to students and students cannot carry medication without a completed Medication Authorization form on file in the Nurse's Office.

Date:________________ Parent/Guardian Signature______________________________

*****Do Not Return This Form Unless Reverse Is Completed By Physician*****

PHYSICAL EXAMINATION PAGE 2
(To be completed by examining physician)

Name ______________________ **DOB** ________________________

Height _____________________ **Weight** ______________________

VISION:
Glasses ____NO ____YES

Contacts ____NO ____YES

VITAL SIGNS:
B/P _____________

Pulse ___________ Resp _______

URINE:

Sugar ____NEG ____POS

Protein ____NEG ____POS

PHYSICIAN RECOMMENDATIONS:

GENITALIA AND HERNIA:

STRUCTURAL ABNORMALITIES:

(Back, chest, arm, leg deformities)

HEENT:

HEART:

LUNGS:

ABDOMEN:

SCHOOL NURSE FOLLOW-UP:

PHYSICIAN'S REPORT

I hereby certify that this student was examined by me and no physical conditions were detected that would render him/her physically unfit to engage in any sport.

Exceptions: None _______ YES (Specify): ____________________________________

EXAMINING PHYSICIAN ____________________________________ Date __________