Department of Education
PHYSICAL EXAM FORM
SECONDARY

School: ___________________________________

Student:		**DOB:**	
☐ Male ☐ Female		Grade:	HR:
Home Address:			
Father/Guardian:		**Mother**/Guardian:	
Place of work:		Place of work:	
Phone: Home:	Work:	Phone: Home:	Work:
Cell:		Cell:	
Email:		Email:	

PART I:
IMMUNIZATION AND TB STATUS:

A copy of the **Official Immunization Record** must be attached. Record must indicate the specific immunizations and the result of a **TB Skin Test** with date when received. Refer to **Board Policy 337** for specific health requirements and **SOP 1200-020.**

TO BE COMPLETED BY PARENTS (before appointment):

Health History: *Please indicate* **age and/or year on past and current medical conditions:**

1.	Anemia		9.	Heart Disease	
2.	Asthma		10.	Hernia	
3.	Chickenpox		11.	Mumps	
4.	Convulsions/Seizure		12.	Rheumatic Fever	
5.	Diabetes		13.	Skin Disorder	
6.	Measles		14.	Tuberculosis	
7.	Hay Fever		15.	Vision	
8.	Hearing		16.	Other	

Please complete and provide additional information at the back:

17.	Head Injuries ☐ Yes ☐ No	Year:	Results:
18.	Fractures, broken bone(s) ☐Yes ☐No	Year:	Results:
19.	Previous hospitalization ☐ Yes ☐No	Year:	Results:
20.	**Allergies (please list)** :	**Any specific reaction(s):**	
21.	**Currently taking medication:** ☐ **Yes** ☐ **No**		
	Name of medication(s):		
	Reason/Diagnosis:		
22.	Disability: ☐ HV ☐ 1R		
23.	Prosthesis: ☐ **Yes** ☐ **No**		
24.	Any medical reason why this child should NOT participate in Physical Education or related activities? ☐ Yes ☐ No		
25.	Has anyone in the athlete's family (grandparents, mother, father, brother, sister, aunt, uncle etc.) died suddenly before age 50? ☐ Yes ☐ No		
26.	Has the athlete ever stopped exercising because of dizziness or passing out during exercise? ☐ Yes ☐ No		
27.	Does the athlete have asthma (wheezing), hay fever or coughing spells after exercise? ☐ Yes ☐ No		
28.	Has the athlete ever had a broken bone, had to wear a cast, or had an injury to any joint? ☐ Yes ☐ No		
29.	Does the athlete have a history of concussion (getting knocked out)? ☐ Yes ☐ No		
30.	Has the athlete ever suffered a heat-related illness (heat stroke)? ☐ Yes ☐ No		
31.	Does the athlete have a chronic illness or see a doctor regularly for any KHDOWK FRQFHUQ? ☐ Yes ☐ No		

32.	Does the athlete have only one of any paired organs (eyes, ears, kidneys, testicles, ovaries)? ☐ Yes ☐ No
33.	Has the athlete had an injury in the last year that caused the athlete to miss 3 or more consecutive days of practice or competition? ☐ Yes ☐ No
34.	Has the athlete had surgery or been hospitalized in the past year? ☐ Yes ☐ No
35.	Has the athlete missed more than 5 consecutive days of participation in usual activities because of illness, or has the athlete had a medical illness diagnosed that has not been resolved in the past year? ☐ Yes ☐ No
36.	Are you, the athlete, worried about any problem or condition at this time? ☐ Yes ☐ No
Please give details on any **"Yes"** answer(s) from the above health history.	

NOTE: Please notify the School Health Counselor or School Administrator if there are any changes in the health status of the student.

☐ Students must submit valid documentation showing completion of a **Physical Examination**, **Immunization**, results of **TB Skin Test and/or TB Clearance issued by DPHSS** and an **Emergency Information and Health Form**.

☐ Students who plan to participate in Interscholastic Activities/Athletics must submit **a completed Interscholastic Sport Association (ISA) Form**.

Parent/Guardian (print) **Signature** **Date**

PART II:
PHYSICAL EXAMINATION – COMPLETED BY HEALTH CARE PRACTITIONER:

T-P-R-BP: _____/_____/_____/_____

Height: _____ **Vision:** Right 20/___ Corrected: ☐ Yes ☐ No **Hearing:** Right _____

Weight: _____**BMI:**_____ Left 20/____ Contacts: ☐ Yes ☐ No Left _____

Complete Each Item Below	Normal		Describe Findings if Abnormal or Reason for not Examining
	Yes	No	
General appearance			
Skin			
Hair			
Nails			
Eyes: External (Pupil/Cornea)			
Optic Fundus			
Auditory Acuity			
Muscle Balance			
Ears: External			
Auditory Acuity			
Tympanic Membrane			
Nose			
Mouth			
Pharynx			
Larynx			
Speech			
Teeth/Gums			
Neck/Lymph/larynx			
Cardiovascular			
Respiratory			
Gastro Intestinal			
Genital-Urinary			
Muscular Skeletal			
Scoliosis Screening			
Neurological Impressions			
Nutritional Status			
Behavior during Examination			
Other			

PART III
LABORATORY TEST:

Hemoglobin:	Date:	**Hematocrit:**	Date:

Other Test *Date* *Results*

Other Test *Date* *Results*

Summary of Findings, Treatments and Recommendations:

Diagnosis/Findings	Advice and Treatment Given	Recommendations and Follow-Up Plan

PART IV
CLEARANCE FOR ATHLETICS

For School Year: 20 19 to 20 20

I certify that the above student has been medically evaluated and is deemed medically eligible to: (check only one (1) box)

☐ 1. Participate in all school interscholastic activities without restrictions.

☐ 2. Participate in any activity not crossed out below.

SPORT CLASSIFICATION BASED ON CONTACT		
COLLISION CONTACT SPORTS	**LIMITED CONTACT SPORTS**	**NON-CONTACT SPORTS**
Basketball Cheerleading Diving Football Gymnastics Rugby Soccer Wrestling	Baseball Field Events: ➢ High Jump ➢ Pole Vault Softball Volleyball	Badminton Bowling Cross Country Running Dance Team Field Events: ➢ Discus ➢ Shot Put Golf Racquetball Swimming Tennis Track & Field

☐ 3. Requires additional medical evaluation before a final recommendation can be made.

☐ 4. Not medically eligible for: ☐ All Sports

☐ Specific Sport

Specify: _____

I have examined the student named on this form. The athlete does not have any apparent clinical contraindications to practice and participate in the sport(s) as outlined on this form. If conditions arise after the athlete has been cleared for participation, the Physician or Health Care Provider may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete and Parent/Guardian

_____

Health Care Practitioner (print) **Signature** **Date**

_____

Clinic name **Contact Number(s)**