

William S. Hart Union High School District

CERTIFICATE OF PHYSICAL EXAMINATION

Name _____ DOB _____ / ____ / ____

Height _____ Weight _____ Pulse _____ BP _____ / ____

Please place a “✓” as either Normal or Abnormal for all findings below. Please describe in detail all abnormal findings.

	Normal	Abnormal	Comments
Heart			
Pulses			
Lungs			
Neck			
Back			
Shoulder/Arm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle/Foot			
Other pertinent medical findings			

Additional comments: _____

List any restrictions and duration: _____

I hereby certify that _____ was examined by me on _____ 201_____

and found to be physically fit to engage in athletics.

Physician's Signature _____ **Date** _____

Stamp name or attach card of medical office here ▼

Back side to be completed by parent/guardian before physical exam.

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MEDICAL HISTORY TO BE COMPLETED BY PARENT/GUARDIAN BEFORE PHYSICAL EXAM

Name of Student-Athlete _____ Sex _____ Age _____ DOB _____ / ____ / ____

Grade _____ School _____ Sport(s) _____

Y or N (Circle Y or N. If "Yes" explain)

1. Has the student-athlete had a medical illness or injury since his/her last check up or sport physical? _____ Y N

2. Is the student-athlete currently taking any prescription or nonprescription (over-the-counter) medication or using an inhaler? _____ Y N

3. Does the student-athlete have any allergies (for example, pollen, medicine, food, or stinging insects)? _____ Y N

4. Has the student-athlete ever had a seizure? _____ Y N

5. Has the student-athlete ever become ill from exercising in the heat? _____ Y N

6. Is there any pertinent medical information coaches or physicians should know about the student-athlete? _____ Y N

7. Does the student-athlete wear glasses, contacts, or dental braces? _____ Y N

Parent/Guardian Signature

Date