FOR SCHOOL USE ONLY
Date of Physical exam
____/_____/____
Day Month Year

Saint Joseph High School

Student Athlete Physical Examination

Name____ Home Phone No.________________

Address____Grade__________ Age________

Part A and B to be completed by parent/guardians

A. GENERAL HISTORY: Check each answer for each Item.

YES	NO		YES	NO	
☐	☐	1. Diabetes	☐	☐	10. Absence of kidney
☐	☐	2. Seizures	☐	☐	11. Absence of any organ
☐	☐	3. Dizziness, Fainting	☐	☐	12. Menstrual disorder
☐	☐	4. Bleeding disorders	☐	☐	13. Presently under physician care
☐	☐	5. Asthma, allergies	☐	☐	14. Loss of consciousness
☐	☐	6. Heart disease	☐	☐	15. Any changes of health during the past year?
☐	☐	7. Hearing problems			
☐	☐	8. Taking medication, (reason)	☐	☐	16. Give date of last tetanus shot
☐	☐	9. Hernia	☐	☐	17. High blood pressure

Details of any YES answers____

B. ORTHOPEDIC HISTORY: If the student has had, or now has, any of the following areas injured please give details:

1. Shoulder, arm, elbow, wrist, hand, fingers, or thumb injury: type/when?______________________________
2. Hip, knee, leg, calf, ankle, foot, or toe injury: type/when?______________________________
3. Head, neck, or spine injury: type/when?______________________________

Familydoctor:______________________________________Phone(___)____________________

I verify that the above information is correct and I give permission for my child to receive a physical examination.

____

Date Parent Signature Date Student Signature

Part C, D, & E, to be completed by examining physician

C. PRE-PHYSICAL

Height________ Weight________ Blood Pressure________ Vision: Right_____ Left_____

Dental: Braces broken or missing teeth Plates Glasses: YES NO Contacts: YES NO Anisocoria: Yes NO

D. GENERAL PHYSICAL

Heart_________________________ Lungs__________________________ Abdomen_________________________

Hernia____Varicocele______________________________________

E. ORTHOPEDIC EVALUATION

C Spine_______________________ T Spine__________________________ L Spine_________________________

Hips/ Pelvis____________________ Knees___________________________ Feet Ankle/Toes____________________

Sholders_______________________ Elbows__________________________ Wrist/Hands/Fingers_______________

☐ Approved for athletic competition

☐ Disapproved foe athletic competition, state reason ____

☐ Approved for athletic competition, refer to specialist for____________________________________

☐ Disapproved for athletic competition, refer to specialist for__________________________________

________________________________ ________________________________ __________________

Signature of physician Telephone number of physician Date

________________________________ ________________________________ __________________

Print name of physician Address of physician Medical license number