STUDENT HEALTH HISTORY

Student:_____ **ID #:** _____

A. **GENERAL HISTORY** Check an answer for each item

YES	NO			YES	NO	
☐	☐	1.	Diabetes	☐	☐	11. High or low blood pressure
☐	☐	2.	Seizures	☐	☐	12. Hernia
☐	☐	3.	Dizziness	☐	☐	13. Absence of a kidney
☐	☐	4.	Bleeding disorders	☐	☐	14. Absence of or, undescended testicle
☐	☐	5.	Asthma, allergies	☐	☐	15. Absence of any organ
☐	☐	6.	Heart disease	☐	☐	16. Menstrual Disorder
☐	☐	7.	Hearing problems	☐	☐	17. Under physician's care at present
☐	☐	8.	Taking medication (type, reason, dosage)	☐	☐	18. Loss of consciousness
☐	☐	9.	Any allergic reactions	☐	☐	19. Change in health during the past year
☐	☐	10.	Have you ever been hospitalized?	☐	☐	20. Give date of last tetanus shot _____

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, 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? _____

Family doctor: _____

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

Date:_____ **Parent/Guardian Signature:**_____ **Phone #:**_____

STUDENT ATHLETE PHYSICAL EXAMINATION

A. PRE-PHYSICAL

Height: _____ Weight: _____ Blood pressure: _____ Vision: Right: _____Left:_____

Dental: Braces / Broken or missing teeth / Plates Glasses: YES NO Anisocoria: YES NO (unequal pupils)

B. GENERAL PHYSICAL

Heart _____ Lungs _____ Abdomen _____

Hernia _____ Varicocele _____

C. ORTHOPEDIC EVALUATION

C Spine: _____ T Spine: _____ L Spine: _____

Hips/pelvis:_____ Knees: _____ Feet/ankles/toes: _____

Shoulders: _____ Elbows: _____ Wrists/hands/fingers_____

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☐ Approved for athletic competition

☐ Disapproved for athletic competition, state reason: _____

☐ Approved for athletic competition, refer to specialist for: _____

☐ Disapproved for athletic competition, refer to specialist for: _____

_____	_____	_____
DATE OF PHYSICAL	**PRINT NAME OF PHYSICIAN**	**SIGNATURE OF PHYSICIAN**
_____	_____	_____
MEDICAL LICENSE #	**PHONE # OF PHYSICIAN**	**ADDRESS OF PHYSICIAN**