

# SGS Physical Examination Form for School Year 20\_\_ - 20\_\_

## 5th - 8th GRADE STUDENTS ONLY

*This form must be completed and signed by your physician and turned in the first day of tryouts or practice.*

My child participates in  football  basketball  volleyball  track  cheerleading  cross country  golf  dance team  swim team

Name \_\_\_\_\_ Social Security No. \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex:  Male  Female

Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_

HEALTH HISTORY		
Explain all yes answers in parent summary.		
	Yes	No
1	Chronic/recurrent illness?	
2	Hospitalization	
3	Surgery other than tonsils?	
4	Injuries treated by MD?	
5	Current medications?	
6	Organs missing?	
7	Heat exhaustion/stroke?	
8	Dizziness, fainting, convulsions, and/or headaches?	
9	Fainting during exercise?	
10	Knocked out? Date(s)?	
11	Concussions? Date(s)?	
12	Wear glasses or contacts?	
13	Hearing defects?	
14	Dental appliances, bridge, braces, caps or plate?	
15	Cough/chest pain?	
16	Problems with blood pressure, heart or murmur?	
17	Problems with liver, spleen, or kidneys?	
18	Hernia?	
19	Recurrent skin diseases?	
20	Bone, joint injury, sprain, dislocation?	
21	Allergy to medications? Name:	
22	Tetanus booster in the last 10 years? Year _____	
23	Any sudden deaths before age 50 in immediate family?	
24	Recent TB skin test? Date _____ Result _____	
25	Previous laboratory-acquired illness?	
26	Exercise induced asthma?	

PARENT SUMMARY OF COMMENTS:	
Item No.:	Description:
<i>Parent Signature</i>	<i>Date</i>

PHYSICIAN COMMENTS:			
	Satisfactory Yes / No	Physical Evaluation Comments	Recommend Follow-Up
Vitals			
Head			
Neck			
Eyes			
ENT			
Dental			
Chest			
Heart			
Abdomen			
Genitalia			
Skin			
Allergy			

PHYSICIAN SUMMARY OF COMMENTS:	
( ) Cleared ( ) Not Cleared	
<i>Physician Signature</i>	<i>Date</i>

ADDITIONAL COMMENTS: