St. George School Examination Form 20____-20_____Year

3rd - 8th Grade Students Only

This form must be completed/signed by the physician and turned in before first day of practice

Circle your sport choic (es) **Football** **Basketball** **Volleyball** **Cross Country**
Track **Swimming** **Cheerleader** **Dance Team**

Student Name: _____ Grade: _____
Date of Birth: _____ Sex: Male or Female (circle)
Height:_____ Weight: _____ Pulse:_____ BP:_____

Health History--Explain all "Yes" Answers in Parent Summary On Back Side

	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/Stoke?		
8.) Dizziness, Fainting, Convulsions?		
9.) Fainting During Excercising?		
10.) Frequent Headaches?		
11.) Knocked out? Date(s)_____		
12.) Concussions? Date(s)_____		
13.) Wears Glasses or Contacts?		
14.) Hearing Defects?		
15.) Cough/Chest Pains?		
16.) Problems with Blood Pressure, Heart or Murmurs?		
17.) Problems with Liver, Spleen or Kidney?		
18.) Recurrent Skin Diseases?		
19.) Dental: Braces, Caps, Plates, Bridges?		
20.) Bone, Joint Injury, Sprain or Dislocations?		
21.) Hernia?		
22.) Tetnus Booster in Last 10 Years?		
Year:_____		
22.) Allergy to Medications?		
If so, Name:_____		
23.) Excercised Induced Asthema?		
24.) Any Sudden Deaths Before Age 50 in Immediate Family		
25.) Recent TB Skin Test?		
26.) Previous Laboratory Acquired Illness		

CONTINUE ON BACK SIDE

PHYSICIAN COMMENTS:_____

_____

	SATISFACTORY:		**Doctor Evaluation**	**Recommended**
	YES	**NO**	**Comments:**	**Follow Up:**
Vitals				
Head				
Neck				
Eyes				
ENT				
Dental				
Chest				
Abdomen				
Genitalia				
Skin				
Allergy				

Physician's Summary of Comments:

( ) Cleared **( ) Not Cleared**

Physician Signature:_____ Date:_____

Parent Summary of Comments:

Item #	**Description**

Additional Comments: _____