To be completed by Parent/Guardian before physical examination

Student's Name _____Grade _____

1. Has the student ever had a disease that affects the function of the

   Eyes?_____Ears?_____Kidneys?_____Lungs?_____

2. List any surgical operations/procedures with age and/or date:

---

3. List any broken bones, sprains, muscle or tendon injuries with age and/or date:

---

4. Has the student had any of the following? Please circle yes or no.

Asthma	Y	N	Hepatitis	Y	N
Allergies	Y	N	Heart Murmur	Y	N
Blood Disorders	Y	N	Heat Stroke/Exhaustion	Y	N
Concussion	Y	N	Kidney Disease/injury	Y	N
Diabetes	Y	N	Seizure Disorder	Y	N
Fainting/Convulsion	Y	N	Other Serious Illness	Y	N
Head Injury	Y	N			

   Please explain any YES answers to above questions:

_____

5. Does the student take any medication now? _____If so, what?_____

6. Does the student wear glasses or contact lenses? _____

I have answered this medical questionnaire to the best of my knowledge and give permission for my child to have their physical exam done by our school physician, Dr. Martin Iser.

_____ _____

Parent/Guardian Signature Date

To be completed by Physician and Nurse

NAME: _____

HEIGHT _____WEIGHT_____BLOOD PRESSURE _____

SIGNIFICANT PAST ILLNESS OR INJURY _____

_____

_____

Specific Examination	Essentially Normal	Abnormal	Comments
1. Head			
2. Eyes			
3. Ears			
4. Neck			
5. Chest/Lungs			
6. Heart			
7. Abdomen			
8. Neurological			
9. Hernia Check			
10. Muscle/Skeletal			

Based on medical history and this examination, this student may participate in athletic activities.

_____without restriction

_____with restrictions, as follows

_____

_____

_____ _____

Examining Physician Date of Examination