

Immanuel Lutheran School
Athletic Physical Examination Form
 (to be completed by the athlete's parents)

Athlete Information

Student Name _____ Birth date _____ Grade _____
 Address _____ City _____ State _____
 Home Phone _____ Zip Code _____
 Father's Name _____ Mother's Name _____
 Personal Physician _____

Medical History

(Explain all YES answers at bottom of the page)

	Yes	No
1. Is your child currently under a physician's care?	_____	_____
2. Has your child ever been hospitalized?	_____	_____
3. Have they ever had surgery (tonsillectomy, arthroscopy, etc.)?	_____	_____
4. Is your child currently taking any medications or pills?	_____	_____
5. Do they have any allergies (hay fever, hives, eczema, medicines, stinging insects, etc...)?	_____	_____
6. Do they have asthma, trouble breathing or a cough during or after physical activity?	_____	_____
7. Has your child had any problems with their eyes or vision?	_____	_____
8. Do they wear glasses, contacts or protective eyewear?	_____	_____
9. Do they wear any dental appliances (braces, false teeth, etc.)?	_____	_____
10. Has your child had any serious medical problems (diabetes, hepatitis, mononucleosis, etc.)?	_____	_____
11. Have they had any problems with injuries to muscles, bones, or joints?	_____	_____
12. Does your child have ear drum tubes or a perforated eardrum?	_____	_____
13. Date of last tetanus (Td) shot _____ Date of last Measles (MMR) _____		

Comments: _____

Parent/Guardian's Signature

Date

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(to be completed by the physician)

Date _____

Student Name _____

Height _____ Weight _____ Blood Pressure _____ Pulse _____

Eyes: Left: 20/____ Right: 20/____ _____ With or _____ without correction

General Appearance (please indicate satisfactory +; unsatisfactory X; not examined O)

Nutrition _____ Ears _____ Nose _____ Throat _____

Teeth _____ Skin _____ Heart _____ Lungs _____

Hernia _____ Genitals _____ Abdomen _____ Lymph nodes _____

Musculoskeletal

Back _____ Shoulders _____ Hips _____ Knees _____

Ankles, feet _____ Elbow, wrist, hand _____

Other observations/concerns

Please Check One

_____ Cleared for participation in all sports

_____ Not Cleared for participation in all sports

Licensed Health care provider signature: _____

Licensed Health care provider printed name: _____