

**GREENWOOD SCHOOL  
2019-2020 School Year  
PHYSICAL HEALTH EXAMINATION FORM**

**This completed form is necessary for ALL students**

Student's name \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_ Sex: M F

Parent/Guardian's name \_\_\_\_\_ Home Phone \_\_\_\_\_

Home address \_\_\_\_\_  
Street City State Zip

Father work phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Mother Work phone \_\_\_\_\_ Cell phone \_\_\_\_\_

**PARENT / GUARDIAN - check yes or no to the following questions pertaining to your child. If yes, please explain.**

YES NO

	Chronic or recurrent illness?
	Illnesses lasting more than a week?
	Hospitalizations?
	Surgery other than tonsillectomy?
	Injuries requiring treatment from a physician?
	Problems with blood pressure and/or heart?
	Dizziness, fainting, convulsions or frequent headaches?
	Knee injury?
	Ankle injury?
	Neck injury?
	Other joint sprains, dislocations, broken bones?
	Heat exhaustion or heat stroke?
	Concussion or unconscious?
	Allergies or allergic to medication?
	Taking medication at the present time?
	Use drugs?
	Wear glasses or contact lenses?
	Wear dental appliances such as braces, bridge or plates?
	Have to stop running around a ¼ mile track?
	Have any family members under the age of 50 had any heart or blood pressure problems?
	Do any family members have diabetes?
	Has any family member under the age of 50 died suddenly?
	Any missing organs other than tonsils?

Date of last tetanus shot? \_\_\_\_\_

Additional information \_\_\_\_\_

**PARENT OR GUARDIAN READ AND SIGN:** I certify that the information above is true and I consider my child physically capable of participating in athletics. I hereby give my consent for the above named student (1) to participate in athletic activities at school, except for exceptions cited by the examining physician and (2) to accompany the school team of which he/she is a member to any of its local or out-of-town trips. I further authorize the school to obtain any emergency medical care that may become necessary for the student in the course of such athletic activities or such travel and understand that the cost of such treatment will be at my expense. I also agree not to hold Greenwood School or anyone acting in its behalf responsible for any injury occurring to the above named student in the course of such athletic activities or such travel. I also grant permission to Greenwood School to release any and all athletic injury information relating to the above named student to the Sports Medicine Program Injury Registry.

Parent signature \_\_\_\_\_ Date \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy number \_\_\_\_\_ (OVER)

***Be sure to complete both sides of this form.***

**PHYSICAL EXAMINATION\***  
**\*PHYSICIAN to complete this side of form.**

Student Name \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse rate \_\_\_\_\_ Blood pressure \_\_\_\_\_

Vision (without glasses) RT \_\_\_\_\_ LT \_\_\_\_\_ (With glasses) RT \_\_\_\_\_ LT \_\_\_\_\_

	Normal	Abnormal	Comments
HEENT			
CARDIO-PULMONARY			
ABDOMEN			
GENITALIA-HERNIA			
SKIN-LYMPHATICS			
SPINE-SCOLIOSIS SCREENING			
MUSCULO-SKELETAL			
NEUROLOGICAL			
Urinalysis (dipstick) (Optional) _____ Fat % _____			
HEMATOCRIT / HEMOGLOBIN (Optional) GMS _____ %			

**RECOMMENDATIONS**

\_\_\_\_\_ There were no findings in the Health History or on the Physical Examination that would prohibit this student from participating in interscholastic athletics and/or Physical Education class. This student **may participate** fully in physical education and interscholastic athletics activities.

\_\_\_\_\_ This student must have the following health problem(s) evaluated prior to participating in Interscholastic athletics and/or Physical Education class.\*\*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\*\* Complete this section only if health problems were found.

TO EXAMINING PHYSICIAN: Upon completion of your examination and evaluation of this student for the health problem(s) listed above, please list your diagnosis, check one of the appropriate spaces and sign this form.

DIAGNOSIS: \_\_\_\_\_

\_\_\_\_\_ Student may participate in physical education and interscholastic athletic activities with NO RESTRICTIONS.

\_\_\_\_\_ Student may participate with the following limitations \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ Student may not participate in physical education or interscholastic athletic activities.

PHYSICIAN'S SIGNATURE \_\_\_\_\_ DATE OF EXAM \_\_\_\_\_

Physician's name \_\_\_\_\_ Phone \_\_\_\_\_

**Be sure to complete both sides of this form.**