

PHYSICAL EXAMINATION FORM

Name: _____ Date: _____

Height: _____ Weight: _____ BP: _____ P: _____ R: _____

Urine: Spec. Gravity: _____ pH: _____ Glucose: _____ Protein: _____

Vision: Rt. 20 / Left: 20 / Both: 20 / No correction Contacts Glasses (*Circle one*)

BODY PART	NORMAL	ABNORMAL FINDINGS
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart/Pulse		
Lungs		
Abdomen		
Genitalia (Males only)		
Skin		
Neck		
Back		
Shoulder		
Arm		
Elbow		
Wrist/Hand		
Hip		
Leg		
Knee		
Ankle/Foot		

CLEARED WITHOUT LIMITATIONS
 CLEARED AFTER completing evaluation/rehabilitation for: _____
 DISQUALIFIED due to: _____

Other recommendations: _____

Signed: _____ Name/Title of Examiner: _____

Address: _____

Phone: _____ Date of Exam: _____

Physical is valid for one year from the date of your doctor visit

The following are considered disqualifying factors until medical and parental releases are obtained: Acute infections, obvious growth problems, diabetes, jaundice, severe visual or hearing loss, pulmonary insufficiency, organic heart disease, hypertension, enlarged liver or spleen, hernia, musculoskeletal deformities or functional loss, history of convulsions or concussion, absence of one kidney or eye or testicle.



PARENTAL PERMISSION

This form must be completed and filed in the athletic office BEFORE the student can participate in athletics

As parent or legal guardian of _____, I give permission for her/him to participate in any events related to her/his team, including overnight trips. I certify that the information on this form is correct, and we agree to abide by the eligibility rules and regulations governing athletics of any and all associations to which CDS is a member. Furthermore, I the undersigned do grant to the officials of the above named school permission for the treatment deemed necessary for any condition arising during the participation in these activities, including medical or surgical treatment recommended by a medical doctor or dentist. I understand that every effort will be made to contact me prior to the treatment, but treatment will not be delayed due to the inability to reach me. I understand that CDS does not provide primary student medical insurance and all medical expenses resulting from participation in the CDS athletic program are solely my responsibility (supplemental insurance is required which CDS offers). I agree to the need for a screening medical examination and I certify that the medical history is accurate to the best of my knowledge.

Signature _____ Date _____
Parent or Guardian

Student's full name _____ Grade _____ Birthdate _____

Address _____ City _____ State/Zip _____

Home Phone _____ Email _____

Father's Name _____ Work/Cell Phone _____

Mother's Name _____ Work/Cell Phone _____

Physician's Name _____ Physician Phone _____

Insurance Co _____ Policy # _____

MEDICAL HISTORY to be completed by parent or guardian Date of Last Tetanus Booster _____

Is there a history of:	Circle One	
Allergies (food, drugs, other)	yes	no
Birth defects or missing organs	yes	no
Known past illness greater than 1 week	yes	no
Medical conditions currently under treatment	yes	no
Fractures, sprains, twisted joints or other injury	yes	no
Any permanent deformities or disabilities	yes	no
Any surgery	yes	no
Convulsions, seizures, mental disorders	yes	no
Loss of consciousness, fainting, knocked out	yes	no
Has any family member died suddenly	yes	no
Any chest pain or shortness of breath during exercise	yes	no

Explain all "yes" answers: _____

