

Loving Municipal Schools

Physical Form

HEALTH QUESTIONNAIRE (Parent or Guardian to complete and sign Health Questionnaire)

NAME _____ FAMILY PHYSICIAN _____

ADDRESS _____ PHONE _____

AGE _____ DOB _____ GRADE _____ SEX _____

LAST TETANUS BOOSTER _____ MEDICAL ALLERGY _____

YES	NO	DON'T KNOW	
			1. Anyone in the family (Parent, Grandparent, Uncle, Aunt) DIED Before Age 50?
			2. Has Patient ever had a concussion? Been knocked out?
			3. Does the patient have Asthma, Wheezing, Hay fever, Coughing spell after exercise?
			4. Has the patient ever had a broken bone, had to wear a cast, or had an injury to any joint?
			5. Has the patient ever passed out or had to stop exercising because of dizziness?
			6. Has the patient ever suffered a heat related illness?
			7. Does the patient have a chronic illness or see physician regularly for any problems?
			8. Does the patient take any medication regularly?
			9. Does the patient have any missing organs (EYE, Kidney, Testicles, Etc.)?
			10. Has the patient had any surgery?
			11. Does the patient have anything He/She wants to talk to the Doctor about?

Please Explain any "YES" Answers _____

The Above information is current and correct to the Best of my knowledge.

SIGNATURE PARENT/GUARDIAN _____ DATE _____

-----Physicians Exam (Physician please review questionnaire, complete exam, and check participation approval)-----

BP. _____ WT. _____ HT. _____ R. _____ L. _____ Corrected? _____

LAB (If Indicated) HGB/HCT _____ UA _____

	NORMAL	ABNORMAL	COMMENTS
1. EARS, NOSE THROAT	_____	_____	_____
2. Pulmonary Exam	_____	_____	_____
3. Cardiovascular Exam	_____	_____	_____
4. Abdomen Exam	_____	_____	_____
5. Genital Exam	_____	_____	_____
6. Musculoskeletal Exam			
A) Knees	_____	_____	_____
B) Ankles	_____	_____	_____
C) Shoulders	_____	_____	_____
D) Other Joints	_____	_____	_____
E) Back	_____	_____	_____
F) Feet	_____	_____	_____
G) Estimate Flexibility	_____	_____	_____
H) Estimate Strength	_____	_____	_____
7. Skin Exam	_____	_____	_____

Sports Participation Approved YES NO Limitations: _____

Reexamine: _____ Yearly and after injury that limits participation for more than I week
 _____ Other: _____

Physician Signature _____ Date _____

Address _____ Phone _____

