



## MEDICAL HISTORY AND PHYSICAL

Parent should complete this side of form PRIOR to appointment with physician

STUDENT NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ GRADE \_\_\_\_\_ for school year 2016 - 2017

PARENT/GUARDIAN NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

### HEALTH HISTORY:

*Has this student had any:*

YES NO

1.   chronic or recurrent illnesses?
2.   hospitalizations?
3.   surgery?
4.   missing organs (eye/kidney/testicle)?
5.   heart condition?
6.   seizures/epilepsy?
7.   fainting spells ?

*Does this student:*

YES NO

8.   wear eye glasses or contact lenses?
9.   wear dental bridge, braces, plates?
10.   take any medications?
11.   wear a prosthesis?
12.   have any allergies?
13.   have any physical limitation?
14.   have difficulty hearing?

EXPLAIN ANY "YES" ANSWERS \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

HAS THIS STUDENT EVER HAD A CONCUSSION OR LOSS OF CONSCIOUSNESS?  YES  NO

DESCRIBE: \_\_\_\_\_

DATES OF ANY IMMUNIZATIONS DURING THE PAST YEAR \_\_\_\_\_

DESCRIBE ANY OTHER SIGNIFICANT PHYSICAL, BEHAVIORAL OR EMOTIONAL CONCERNS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

DATE: \_\_\_\_\_ PARENT/GUARDIAN SIGNATURE \_\_\_\_\_



## PHYSICAL EXAMINATION FORM

*To be completed by physician*

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ BLOOD PRESSURE \_\_\_\_ / \_\_\_\_ PULSE \_\_\_\_\_  
 VISION R 20/\_\_\_\_ L 20/\_\_\_\_ Corrected: Y N

Immunization Dates: TDAP \_\_\_\_\_ TD \_\_\_\_\_ Polio \_\_\_\_\_ MMR \_\_\_\_\_ Varicella \_\_\_\_\_

EXAMINATION	NORMAL	ABNORMAL	EXPLANATION
Skin			
Eyes			
E-N-T			
Teeth			
Cardiovascular			
Respiratory			
Abdomen			
Genitalia			
Extremities			
Neurological			
Orthopedic/Spine			
Allergies			
Endocrine			
Laboratory: Urinalysis			
Blood Count			

Recommendations to school health services or other personnel:

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### COMPETITIVE SPORTS CLEARANCE

(Complete if applicable)

I consider \_\_\_\_\_ to be physically fit at the present time and up-to-date on all necessary immunizations. I consider him/her to be capable of participating in all competitive athletics for the coming school year.

**CROSS OUT ANY EXCEPTIONS HERE:** baseball, basketball, cross country, football, golf, soccer, softball, spirit (cheer, poms), swimming, tennis, track and field, wrestling, volleyball.

DATE \_\_\_\_\_

PHYSICIAN'S SIGNATURE \_\_\_\_\_

PLEASE RETURN THIS FORM TO: *University Schools, 6525 W 18 St, Greeley CO 80634; or fax to 970-506-7070*