HOME OF THE BULLDOGS
UNIVERSITY SCHOOLS
6525 W. 18TH ST. GREELEY, CO. 80634

# 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 2015 - 2016

PARENT/GUARDIAN NAME

_____

ADDRESS _____ PHONE_____

HEALTH HISTORY:

| | *Has this student had any:* YES | NO | | | *Does this student:* YES | NO | |
|---|---|---|---|---|---|---|---|
| 1. | ____ | ____ | chronic or recurrent illnesses? | 8. | ____ | ____ | wear eye glasses or contact lenses? |
| 2. | ____ | ____ | hospitalizations? | 9. | ____ | ____ | wear dental bridge, braces, plates? |
| 3. | ____ | ____ | surgery? | 10. | ____ | ____ | take any medications? |
| 4. | ____ | ____ | missing organs (eye/kidney/testicle)? | 11. | ____ | ____ | wear a prosthesis? |
| 5. | ____ | ____ | heart condition? | 12. | ____ | ____ | have any allergies? |
| 6. | ____ | ____ | seizures/epilepsy? | 13. | ____ | ____ | have any physical limitation? |
| 7. | ____ | ____ | fainting spells ? | 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'S SIGNATURE _____

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# 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:

_____

_____

_____

_____

**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*