

SPORTS LIKELY TO \_\_\_\_\_  
PARTICIPATE IN \_\_\_\_\_

**TROY SCHOOL DISTRICT – INTERSCHOLASTIC ATHLETICS**  
**PHYSICAL EXAMINATION, PARENT CONSENT AND STUDENT APPLICATION FORM**

STUDENT NAME \_\_\_\_\_ GRADE \_\_\_\_\_ AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ STUDENT NO \_\_\_\_\_  
LAST FIRST MONTH/DAY/YEAR

ADDRESS \_\_\_\_\_ PHONE(home) \_\_\_\_\_ PHONE (work) \_\_\_\_\_  
NUMBER STREET ZIP CODE

DATE \_\_\_\_\_ 20\_\_\_\_ SCHOOL \_\_\_\_\_ PARENT/GUARDIAN NAME \_\_\_\_\_

**PHYSICAL EXAMINATION** – The examination must occur after April 15 to be valid for the following school year. This section is to be completed, signed, and stamped by the examining physician.

1. Heart condition (circle one):      Satisfactory      Unsatisfactory      2. Lungs(circle one):      Satisfactory      Unsatisfactory
3. Is there evidence of hernia? \_\_\_\_\_ Restrictions \_\_\_\_\_  
\_\_\_\_\_
4. Is the general condition of feet, ears, eyes, and nose satisfactory? \_\_\_\_\_
5. Is the general condition of mouth and throat satisfactory: \_\_\_\_\_  
Is there a bridge or false teeth? \_\_\_\_\_
6. Drug allergies? \_\_\_\_\_      7. Blood pressure \_\_\_\_\_ / \_\_\_\_\_

I certify that I have on this date examined the above student and recommended him/her as being physically able to compete in interscholastic athletic activities except for the following restrictions: \_\_\_\_\_  
\_\_\_\_\_

SIGNATURE OF EXAMINING PHYSICIAN \_\_\_\_\_

DATE OF EXAMINATION \_\_\_\_\_ PHYSICIANS PHONE \_\_\_\_\_

PHYSICIANS STAMP