THE EPISCOPAL SCHOOL OF DALLAS
PHYSICAL EXAMINATION FOR 2020 - 2021

REQUIRED FOR ALL STUDENTS

ESD requires a physical examination of all students **every year**. The physical examination form **must** be signed and dated by the physician.

Student's Last Name _____ First Name _____ Grade in Fall 2020 _____

Birth date _____/_____ /_____ Male _____ Female _____

Home Address _____ Home Phone (_____)

_____

Parent/Guardian's Name _____ Parent/Guardian's Name

_____

To be completed by a parent/guardian:

Y/N Have you ever been advised by a physician during the past year to restrict activity?
Y/N Have you ever been dizzy or passed out during or after exercise?
Y/N Have you ever had chest pain during or after exercise?
Y/N Have you ever been unconscious or had a concussion?
Y/N Have you ever had heat or muscle cramps?
Y/N Have you ever been dizzy or passed out from heat?
Y/N Have any members of your family, under the age of 50, had a heart attack, heart problem, died unexpectedly, or had an unexplained death?
Y/N Have you ever been diagnosed or treated for Sickle Cell disease?
Y/N Are you missing a paired organ? If so, which _____
Y/N Have you ever been diagnosed with a heart murmur, high blood pressure, or heart abnormality?
Y/N Do you wear glasses, contacts, or protective eye equipment?
Y/N Do you use any special equipment (pads, braces, neck rolls, mouth guard or eye guard, etc.)?
Y/N Have you ever had sprains, strains, dislocations, fractures, or had repeated swelling or other injuries of bones?

Check all that apply:

( ) head ( ) shoulder ( ) thigh ( ) neck ( ) elbow ( ) knee ( ) hip
( ) hand ( ) forearm ( ) shin/calf ( ) back ( ) wrist ( ) ankle ( ) foot

If you answered yes to any of the questions above, please explain here:

_____

_____

PHYSICAL EXAMINATION (To be completed by Physician) Exam Date _____

Height _____ Weight _____ Blood Pressure _____ Pulse _____

	WNL or Neg.	Abnormal or Pos.		WNL or Neg.	Abnormal or Pos.		WNL or Neg.	Abnormal or Pos.	VISION	Right Left	Hearing @ 25 dB
Skin	☐	☐	Heart	☐	☐	Joint Function	☐	☐		20/___ 20/____	1k 2k 4k
Head	☐	☐	Abdomen	☐	☐	Spine	☐	☐	Glasses	20/___ 20/____	Right ___ ___ ___
Eyes, Ears, Nose	☐	☐	Genitalia	☐	☐	Acanthosis Nigricans	☐	☐	Contacts	20/___ 20/____	Left ___ ___ ___
Mouth	☐	☐	Upper Extremities	☐	☐	Neck	☐	☐			
Lungs, Chest	☐	☐	Lower Extremities	☐	☐				Scoliosis Screening:		Pass / Fail

Explain any abnormal or positive findings_____

I certify that my examination of the above student has revealed that he/she is physically able to participate in the following activities: all physical education, overnights and athletics programs offered by The Episcopal School of Dallas.

Exceptions (list) _____

No Participation Until (set date) _____ Signature of Examining Physician _____

Telephone (_____) _____ Printed Name of Physician _____ Date _____