Form 2

NORWALK-LA MIRADA UNIFIED SCHOOL DISTRICT
ANNUAL PHYSICAL SCREENING FORM

SPORTS: (fall)________________ (winter)________________ (spring)________________

Name ______________________ Grade_____ Male ____Female____ Date of birth __/__/__

Address ______________________ City & Zip Code________________ Home Phone__________

Name of Father/Guardian______________________ Work phone ______________ Cell phone ______________

Name of Mother/Guardian ______________________ Work phone______________ Cell phone______________

Emergency Contact______________________ Phone Number______________ Insurance ______________

I hereby give my consent for the above named student (son/daughter/ward) to compete in sports and to go with a representative of the school on any trips. In case of injury, you are authorized to have him/her treated.

Signature of parent/guardian ______________________ Date ______________

HEALTH HISTORY: TO BE COMPLETED BY PARENT BEFORE DOCTOR EXAM

Any past or present:	Yes	No
Problems with vision	____	____
Eyeglasses	____	____
Contacts	____	____
Problems with hearing	____	____
Hearing aid	____	____
Blacking out or fainting	____	____
Unconsciousness	____	____
Convulsions, seizures	____	____
Heart problems	____	____
Rheumatic fever	____	____
Bleeding disorders	____	____
Blood sugar problems	____	____
Hypoglycemia	____	____
Diabetes	____	____
Allergies - type ______________		
Bee or insect stings	____	____
Hospitalizations	____	____

	Yes	No
Surgeries	____	____
Dental problems	____	____
braces	____	____
false teeth	____	____
Painful joints	____	____
Broken bones	____	____
Part, date ______________		
Knee or ankle problems	____	____
Require support/brace	____	____
Need for medication	____	____
Name ______________		
Menstruation problems	____	____
Hernias	____	____
Asthma	____	____

OTHER HEALTH ASPECTS THE DOCTOR AND SCHOOL SHOULD BE AWARE OF:
____
____

PHYSICAL EXAM: DATE ______________ HEIGHT ______________ WEIGHT ______________

PULSE: RESTING ______________ AFTER ACTIVITY ______________ B.P. ______________

EYES	____	LYMPH GLANDS	____	POSTURE	____
EARS	____	THYROID	____	MUSCLE TONE	____
NOSE	____	HEART	____	REFLEXES	____
THROAT	____	LUNGS	____	ORTHOPEDIC	____
TEETH	____	ABDOMEN	____	SKIN	____
BRACES	____	HERNIA	____	OTHER	____

I have examined the above student and do recommend that s/he is physically fit for full participation in sports.

Name of physician ______________________ MD or DO Date______________

Signature ______________________ Phone number ______________

Special doctor recommendations or restrictions ______________________

****PLEASE STAMP WITH PHYSICIAN'S OFFICE STAMP****