OAKDALE HIGH SCHOOL
PHYSICAL EXAMINATION FORM

NAME:_____ SPORT:_____ GRADE:_____

DATE OF EXAMINATION:_____ DATE OF BIRTH:_____ SEX:_____

To be completed by Parents

Answer Yes or No Only	Yes	No
Chronic/Recurrent Illness?		
Hospitalization?		
Surgery other than tonsils?		
Injuries treated by physician?		
Current medications?		
Organs missing?		
Heat exhaustion/stroke?		
Dizziness, fainting, convulsions?		
Knocked out?		
Concussion?		
Wear glasses or contacts?		
Hearing Defects?		
Dental appliances- bridges, braces		
Cough/pain?		
Problems with blood pressure, heart or murmurs?		
Problems with liver, spleen, kidneys?		
Hernia?		
Recurrent skin disease		
Bone/Joint injury?		

Sprain/dislocation		
Injury that cause a missed practice or event		
Allergies?		
Allergies to medication?		
Tetanus booster in last 10 years?		

THE INFORMATION PROVIDED ABOVE IS CURRENT AND TRUE TO THE BEST OF MY KNOWLEDGE

_____

PARENT/GUARDIAN SIGNATURE DATE

To be completed by the Physician

VITALS	YES	NO	COMMENTS	RECOMMENDED FOLLOW UP
Height				
Weight				
BP:_____				
General				
Head				
Eyes			Acuity: L R	
ENT				
Dental				
Chest				
Heart				
Abdomen				
Genitalia				
Skin				
Extremities Back/Neck				

Sport Participation Approved: Yes:___ No:___

Limitations:_____

Comments:_____

_____

PHYSICIAN'S SIGNATURE

Date_____