



ST. JOHN'S EPISCOPAL SCHOOL
Athletic Participation Physical Examination
Health History from Parent

5th – 8th GRADE ONLY

NAME _____ BIRTHDATE _____ GRADE _____ M _____ F _____

Home Address _____ City _____ Phone _____

Name of Parent/Guardian _____

Name of Pediatrician/Group _____

Office Address _____ City _____ Phone _____

Health History (to be completed by parent/guardian and reviewed by examining physician) Please answer the following questions by circling “no” or “yes” and explaining as necessary:

- Has this student had a complete physical examination in the past three years? NO YES
- Has this student ever had a concussion or been unconscious? Explain/ Date _____ NO YES
- Has this student ever been disqualified from athletic participation for medical reasons? NO YES
- Does this student have any major medical condition? Explain _____ NO YES
- Has this student had an injury of a muscle, bone, joint, ligament, or tendon? NO YES
- Explain _____
- Has this student ever been hospitalized other than surgery? Explain _____ NO YES

Is this student taking any prescription medication? Explain _____ NO YES

Please indicate the following conditions by circling “no” or “yes” and explaining as necessary:

- | | |
|--|---|
| 1 Wears glasses NO YES | 7 Heart condition NO YES |
| 2 Wears contact lenses NO YES | Explain _____ |
| 3 Any kind of ear problems? NO YES | 8 Kidney problems/blood in the urine NO YES |
| Explain _____ | 9. Asthma NO YES |
| 4 Dizziness or Headaches NO YES | Medication _____ |
| Explain _____ | 10. Seasonal Allergies NO YES |
| 5 Seizures, convulsions or fainting spells. Explain _____ NO YES | Bee Allergy NO YES |
| 6 Loose, chipped, or false teeth NO YES | Food Allergies: _____ |
| | EPI PEN NO YES |

*****OTHER HEALTH ASPECTS THE DOCTOR AND SCHOOL SHOULD BE AWARE OF*****

This health history is complete and accurate to the best of my knowledge. I understand medical information will be shared with coaches. I understand parents must be on site to provide and administer any medications needed for sports. Coaches cannot administer any medications to students and students cannot carry medication without a completed Parent/Guardian Authorized Health Care Provider Request for Medication on file in the Nurse’s Office.

Date: _____ Parent/Guardian Signature _____

*****Do Not Return This Form Unless Reverse Is Completed By Physician*****



To be completed by examining physician or authorized health care provider

Name _____

DOB _____

Height _____

Weight _____

VISION:
 Glasses ___NO ___YES
 Contacts ___NO ___YES

VITAL SIGNS:
 B/P _____
 Pulse _____ Resp _____

ADDITIONAL NOTES:

HEENT:

HEART:

LUNGS:

ABDOMEN:

GENITALIA AND HERNIA:

STRUCTURAL ABNORMALITIES:
 (Back, chest, arm, leg deformities)

PHYSICIAN RECOMMENDATIONS:

SCHOOL FOLLOW-UP:

PHYSICIAN'S REPORT
 I hereby certify that this student was examined by me and no physical conditions were detected that would render him/her physically unfit to engage in any sport.
 Exceptions: None _____ YES (specify): _____
 Examining Physician _____ Date of Exam _____