CORNING UNION HIGH SCHOOL – ATHLETIC PHYSICAL EXAMINATION FORM

_________________________________ Student Name
__________ Grade

Age:______ Date of Birth:_____________ Male:_____ Female:_____

Health History
(To be completed and signed by parent/guardian)

Has your child ever had or does he/she now have any of the following?

	Yes	No	
1	☐	☐	Chronic or recurrent illnesses____________________________
2	☐	☐	Illnesses lasting more than a week ________________________
3	☐	☐	Hospitalizations ____
4	☐	☐	Surgery, other than tonsillectomy _________________________
5	☐	☐	Problem with blood pressure or heart _______________________
6	☐	☐	Concussion ____
7	☐	☐	Dizziness, fainting, or frequent headaches ___________________
8	☐	☐	Knee or ankle injury _____________________________________
9	☐	☐	Joint dislocations ____
10	☐	☐	Broken bones ____
11	☐	☐	Organ missing ____
12	☐	☐	Epilepsy or seizure disorder ______________________________
13	☐	☐	Asthma or shortness of breath _____________________________
14	☐	☐	Diabetes ____
15	☐	☐	Nervous disorder or mental illness __________________________
16	☐	☐	Heat exhaustion or heat stroke _____________________________
17	☐	☐	Wear eyeglasses or contact lenses ____________________
18	☐	☐	Wear dental appliances ____________________________
19	☐	☐	Any reason why student should not participate in sports _____________
20	☐	☐	Family history of death before age 50 _______________________

Parent/Guardian Permission and Release

I declare that the above information is correct to the best of my knowledge. I understand this is a screening examination to determine if any obvious medical problems exist to prevent my child from participating in school athletic events. This examination is not a complete medical examination. You should contact your family physician for your medical needs. If any medical problems are identified in this screening examination, further examination and treatment should be obtained through your physician.

_____________________ Parent/Guardian Signature
_____________________ Student Signature
__________ Date

Health Screening Examination
(To be completed and signed by a physician)

Height: ____________ Weight: ____________

Blood Pressure: ____________ Vision: ____________

Pulse: ____________ After Exercise: ____________

	Normal	Abnormal	Comments
Skin			
Mouth/Pharynx			
Heart			
Lungs			
Abdomen			
Glands			
Muscular/Skeletal			
Hernia & Genitals (males only)			

Based on this history and physical exam, the following abnormalities were found and may need treatment:

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____
____

Recommendations

______ **YES – This student is cleared for school sports**

______ **NO – This student is NOT cleared for school sports**

___________________________ Physician Name/Phone # or Office Stamp

___________________________ Physician Signature
__________ Date