

MEDICAL HISTORY

PARTICIPANTS NAME _____

1	Any injuries requiring medical attention?	YES	NO
2	Any Surgical Operations?	YES	NO
3	Any illness lasting more than a week?	YES	NO
4	Currently under a Physicians care?	YES	NO
5	Currently taking any medications?	YES	NO
6	Wears glasses or contact lenses?	YES	NO
7	Wears a hearing device?	YES	NO
8	Wears braces or other prosthesis?	YES	NO
9	Completed poliomyelitis (sabin) immunization by oral Vaccine?	YES	NO
10	Do you know of any reason that your child should not participate in any sport?	YES	NO
11	Has your child ever been diagnosed with psycholosis?	YES	NO

Please explain any "YES" answer (except # 9) _____

Allergies:	Insurance:
Last Tetanus:	Policy #
Present Medication:	Family Physician:
Other:	Physician Phone:

Parent/Guardian Signature _____

PHYSICIAN USE ONLY

Height:	Weight:	Blood Pressure:
Eyes:	Ears:	Genitalia:
Respiratory:	Cardiovascular:	Neurological:
Liver:	Spleen:	Hernia:
Musculoskeletal:	Skin:	Prior Physical:

Physician's Comments _____

I certify that I have examined this participant on the date indicated. On the basis of the examination requested by the organization and the participants medical history, as provided to me, I have found no medical reason which would prevent this participant from taking part in supervised athletic activities.

Physician's Signature _____

Date _____ / _____ / _____



STATE OF FLORIDA
DEPARTMENT OF HEALTH & REHABILITATIVE SERVICES
STUDENT HEALTH EXAMINATIONS

Date _____

Student's Full Name _____ Phone _____ Age _____ Race _____ Sex _____

Address _____ Birthdate _____

Name of Parent or Guardian _____ School _____

A. HEALTH EXAMINATION

Height _____ Weight _____ Blood Pressure _____

(✓) Normal=N; Abnormal=A	N	A	COMMENT: Abnormal Findings, by number
1. Appearance			
2. Skin/Nose			
3. Head/Scalp			
4. Eyes			
5. Visual Acuity (R & L)			
6. Ears			
7. Auditory Acuity (R & L)			
8. Nose / Throat			
9. Mouth, Teeth and Gums			
10. Chest / Lungs			
11. Heart			
12. Abdomen			
13. Genitals and Anus			
14. Musculo-Skeletal			
15. Neurological			
16. Alertness			
17. Emotional / Mental / Behavior Prob.)			
18. Handicap, physical / other (Specify)			
19. Activity Restrictions (Specify)			
20. Abuse, substance / physical / emotional			
21. Nutrition			
22. Other			

B. HEALTH HISTORY (Serious Illnesses Injuries: explain) _____

(attach narrative if additional space needed)

C. LABORATORY (as indicated)

Hemoglobin/Hematocrit _____ Stool (O & P) _____ type _____
 Lead _____ Sickle Cell _____ Tuberculin test: _____ date _____
 results _____

NAME: _____

TITLE: _____

ADDRESS: _____

(Please Print)

Authorized Signature _____

Date _____