

PLYMOUTH COMMUNITY SCHOOL CORPORATION
HEALTH SERVICES DEPARTMENT – PHYSICAL EXAMINATION

Name _____ M F DOB _____ Grade _____
Last First M

Parents _____ Phone _____

Address _____ School _____

I give consent for my child to compete in the school’s athletic program Y N
(Must have a signature before student can participate in sports) _____

Parent’s Signature

MEDICAL HISTORY

- ADHD Headaches Nosebleeds Rubella Serious Injuries
- Allergies Heart Orthopedic Scarlet Fever
- Asthma Hepatitis Problems Seizures Hospitalizations
- Cerebral Palsy Measles Pneumonia Sickle Cell
- Chicken Pox Menstrual Cramps Pregnancy Anemia Other
- Diabetes Mononucleosis Rheumatic Fever Strep Infection
- Ear Infections Mumps RSV Surgeries

PHYSICIAN’S EXAMINATION

Height _____ Weight _____ Temp _____

Blood Pressure _____ Pulse _____ Eyes _____

Posture _____ Vision R _____ L _____

Nutrition _____ Dentition _____ Ears _____

Nose _____ Hearing (Gross) _____

Throat _____ Heart _____

Glands _____ Lungs _____

Abdomen _____ Orthopedic _____

Hernia _____ Reflexes _____

Scoliosis _____ Urinalysis _____

Skin _____

Physically fit to participate in the physical education program? Y N

Medication (name, dosage, reason):

Physically fit for competitive sports? Y N

Reason for restricted program:

Physician's Name _____ Physician's Signature _____ Date _____
 please print