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 Problems	☐ Scarlet Fever	
☐ Asthma	☐ Hepatitis		☐ Seizures	☐ Hospitalizations
☐ Cerebral Palsy	☐ Measles	☐ Pneumonia	☐ Sickle Cell Anemia	
☐ Chicken Pox	☐ Menstrual Cramps	☐ Pregnancy		☐ 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