TIVERTON ATHLETIC DEPARTMENT
Tiverton High School
PHYSICAL EXAMINATION FORM

To Be Completed by Student: **(Note: Back Side to be Completed by Parent)**

Check all sports you are intending to play:

Football__________ Basketball______ Baseball______ Soccer______ Golf_________

Field Hockey______ Volleyball______ Softball ______ Tennis______ Cheering _____

Student's Name ____ Grade ______

Student's Address____

Date of Birth ____ /____ /____ Present Age ___________

To Be Completed by Physician:

Please read medical history on the reverse side prior to completing your examination..

Legend: ✓ *= Normal* *Anything else, please explain.*

Skin___________________ Lungs___________________ Blood Pressure _____________

Eyes __________________ Abdomen________________ Left Arm _________________

Ears __________________ Nutrition ________________ Right Arm ________________

Nose __________________ Orthopedic_______________ Height ___________________

Neck __________________ Scoliosis Screen __________ Weight ___________________

Glands: Cervical_________ Nervous System __________ Tetanus____ Date: __________

Heart__________________ G.U.____________________

Explain any abnormal findings: ____

____

____

Comments: (Pertinent to athlete's health history on reverse of this exam sheet)

____

____

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______________________________ ______________________________ _____________

Name of Examining Physician Signature Date

May Play _____ May Not Play _____

Guardian or Parental Permission:

Permission is____ / is not ____ granted for my son/daughter to participate.

Signature of Parent/Guardian____________________________________ Date ____________

Health History

Name___________________________________ Date of Birth ____ / ____ / ____ Grade _____

To be completed by Parent before physical can be performed by Physician: Please explain all "Yes" answers at bottom of form.

Yes	No	Item #	Question
		1.	Do you have any allergies to medicines, bees, etc.?
		2.	Do you carry a bee sting anaphylatic kit?
Have you ever:			
		3.	Been hospitalized or had surgery?
		4.	Passed out during exercise or in the heat?
		5.	Been dizzy during exercise or in the heat?
		6.	Had chest pain?
		7.	Had high blood pressure?
		8.	Been told you have a heart murmur?
		9.	Had a rapid heart beat or skipped beats?
		10.	Had anyone in your family die of heart problems or sudden death before the age of 40?
		11.	Do you tire more quickly than your friends during exercise?
		12.	Had a head injury?
		13.	Been knocked out?
		14.	Had a seizure or convulsion?
		15.	Had heat cramps?
		16.	Had a skin problem, fracture, dislocation or severe sprain?
		17.	Had a problem with your back?
		18.	Had a serious medical illness?
		19.	Had or do you have any infectious diseases?
		20.	Do you use special braces or pads?
		21.	Do you wear contact lenses?
		22.	Been advised to restrict your physical activity?
		23.	Had blood in your urine?
		24.	Any illness lasting more than 10 days?
		25.	A family history of diabetes?
		26.	Been told you were tall for your age?
		27.	Are you on any medication?
		28.	Date of your last tetanus injection: / /

Explanation of "Yes" answers:

I agree that all answers are true to the best of my knowledge.

Student's Signature ____ Date _______________

Parent/Guardian Signature ___________________________________ Date _______________