

## William S. Hart Union High School District

### CERTIFICATE OF PHYSICAL EXAMINATION

Name \_\_\_\_\_ DOB \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_

Please place a “✓” as either Normal or Abnormal for all findings below. Please describe in detail all abnormal findings.

	Normal	Abnormal	Comments
Heart			
Pulses			
Lungs			
Neck			
Back			
Shoulder/Arm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle/Foot			
Other pertinent medical findings			

Additional comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List any restrictions and duration: \_\_\_\_\_

\_\_\_\_\_

I hereby certify that \_\_\_\_\_ was examined by me on \_\_\_\_\_ 20\_\_\_\_\_

and found him/her to be physically fit to engage in athletics.

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

Stamp name or attach card of medical office here:

RETURN TO SAUGUS FRONT OFFICE OR ATHLETIC DIRECTOR

William S. Hart Union High School District

MEDICAL HISTORY TO BE COMPLETED BY PARENT/GUARDIAN BEFORE PHYSICAL EXAM

Name of Student-Athlete \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_

Graduation Year \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_
Year that student will graduate high school (ex. "2023")

Check Yes or No (If "Yes" explain)

1. Has the student-athlete had a medical illness or injury since his/her last check up or sport physical? Y [ ] N [ ]

Date of Incident: \_\_\_\_\_ Type of Illness or Injury: \_\_\_\_\_

2. Is the student-athlete currently taking any prescription or nonprescription (over-the-counter) medication or using an inhaler? Y [ ] N [ ]

Type of Medication: \_\_\_\_\_

3. Does the student-athlete have any allergies (for example, pollen, medicine, food, or stinging insects)? Y [ ] N [ ]

Type of Allergy: \_\_\_\_\_

4. Has the student-athlete ever had a seizure? Y [ ] N [ ]

Date of Incident(s): \_\_\_\_\_

5. Has the student-athlete ever become ill from exercising in the heat? Y [ ] N [ ]

Date of Last Incident: \_\_\_\_\_

6. Is there any pertinent medical information coaches or physicians should know about the athlete? Y [ ] N [ ]

Explain: \_\_\_\_\_

7. Does the student-athlete wear glasses, contacts, or dental braces? Y [ ] N [ ]

Explain: \_\_\_\_\_

8. Has the student-athlete ever been diagnosed with a concussion? Y [ ] N [ ]

Date of Incident(s): \_\_\_\_\_

Please indicate the longest amount of time the student-athlete has missed activity due to a concussion: \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_