STUDENT'S NAME _____GD. ___ D.O.B. _____ MALE __ FEMALE __

PHYSICIAN'S EXAM

HEIGHT_____ WEIGHT_____ BLOOD PRESSSURE _____ SPINAL CURVATURE _____

LAST TETANUS TOXOID BOOSTER WAS ON _____

PHYSICAL EVALUATION

_____ I find this student physically qualified to participate in **ALL** supervised sports.

_____This student should have the following problems evaluated prior to participation in **ANY** competitive athletics:

_____

_____

_____

This student has health problems, which **would** prohibit him/her from participating in specific competitive athletics.

YES ___ NO ___

RESTRICTIONS: CIRCLE BELOW

Badminton	Fencing	Ice Hockey	Soccer	Volleyball
Baseball	Field Hockey	Indoor Track	Softball	Water Polo
Basketball	Football	Lacrosse	Swimming	Wrestling
Cheerleading	Golf	Rugby	Tennis	Other_____
Cross Country	Gymnastics	Skiing	Track	_____

In addition to reviewing the health history and immunization records, this certifies that I have performed a complete Physical Exam including evaluation of the musculo-skeletal system.

THIS EXAM IS VALID FOR THIRTEEN (13) MONTHS FROM THE DATE OF THE EXAM. IF THIS PHYSICAL EXAM EXPIRES DURING A SPORT SEASON, THE STUDENT WILL NOT BE ELIGIBLE TO PARTICIPATE (PRACTICE OR PLAY) UNTIL A NEW EXAM HAS BEEN SUBMITTED AND APPROVED BY THE SCHOOL NURSE.

_____	_____	_____	_____
Signature of Physician	Date of Exam	Telephone # of Physician	Physician (stamp)

Please return this form to the School Nurse before the first day of tryouts.

Form reviewed by:

GREENWICH HIGH SCHOOL

PHYSICAL EXAM FORM FOR SPORTS PARTICIPATION

Health History

(To be completed by Parent/Guardian)

Student's Name _____ Address_____

Grade_____ School _____ Sports Being Played (1)_____(2)_____(3)_____

All questions must be answered. All "Yes" answers must be explained in the space provided below. Use additional sheet if necessary.

	Yes	No		Yes	No	
1)	_	_	Allergy – Epipen: **Yes** or **No** (circle)	_	_	Rheumatic Fever
2)	_	_	Head Injury, Concussion, Loss of Consciousness	_	_	Mononucleosis
3)	_	_	Frequent Headaches, Dizziness, Fainting	_	_	Hepatitis
4)	_	_	Visual Impairment	_	_	Asthma Inhaler**, Yes** or **No** (circle)
5)	_	_	Eye Injury, Retinal Detachment	_	_	Recent Viral Illness
6)	_	_	Eyeglasses, Contact Lenses	_	_	Orthopedic Injury, i.e., Knee, Ankle, Shoulder
7)	_	_	Hearing Impairment	_	_	Broken Bones
8)	_	_	Dental Bridge, Plate, Braces	_	_	Neck, Spine, or Low Back Injury
9)	_	_	Heart Problem, Murmur, Arrhythmia	_	_	Scoliosis
10)	_	_	High Blood Pressure	_	_	Hospitalizations
11)	_	_	Chest Pain, Fainting During Exercise	_	_	Surgery
12)	_	_	Cough, Wheeze, Shortness of Breath With Exercise or Cold Weather	_	_	Death of Family Member Younger Than 40 Years of Age Due to Illness
13)	_	_	Heart Attack or Stroke of Family Member Younger Than 50 Years of Age	_	_	Skin Disorder
14)	_	_	Gastrointestinal Problems	_	_	Heat Stroke, Heat Exhaustion
15)	_	_	Kidney, Urinary Tract Problems	_	_	Medications at Present
16)	_	_	Chronic or Recurrent Illness	_	_	Missing Organs
17)	_	_	Blood Clotting Disorder	_	_	Menstrual Disturbance
				_	_	Other Information

EXPLANATION: _____

_____

_____

I give permission for release of appropriate information from this sports form to the coach and his/her staff for maintenance of a healthy and safe environment while participating in the sports program. (I will update as appropriate during the school year). In addition, I am aware of the risk inherent in athletics and hereby give permission for my child to tryout and participate.

_____ _____

Signature of Parent or Guardian Date

PLEASE HAVE PHYSICIAN COMPLETE REVERSE SIDE.