

ST. EDWARD CATHOLIC SCHOOL ATHLETIC PHYSICAL REPORT

Name: _____ Sex: _____ Date: _____

Date of Birth: _____ Age: _____

Medication(s): _____

Health History: Please check one

	Y	N		Y	N
Major Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Hosp. Admission	<input type="checkbox"/>	<input type="checkbox"/>	TB	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Eye Injury	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>
Severe Sprains	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>

Dates/Detail of all YES answers: _____

Physicians Report

Ht. _____ Wt. _____ BP _____ P. _____ R.R. _____

	N	AB		N	AB
HEENT	<input type="checkbox"/>	<input type="checkbox"/>	Gait	<input type="checkbox"/>	<input type="checkbox"/>
Neck	<input type="checkbox"/>	<input type="checkbox"/>	Shoulders	<input type="checkbox"/>	<input type="checkbox"/>
Chest	<input type="checkbox"/>	<input type="checkbox"/>	Upper Extremity	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>	Lower Extremity	<input type="checkbox"/>	<input type="checkbox"/>
Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Spine	<input type="checkbox"/>	<input type="checkbox"/>
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	Reflexes	<input type="checkbox"/>	<input type="checkbox"/>
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>

Circle One: This student MAY MAY NOT participate in school athletics.

Restrictions: _____

Physician's Signature: _____ Date: _____

Office Number: _____