

STUDENT PARTICIPATION AND PHYSICAL EXAM CARD

(PLEASE TYPE OR PRINT)

STUDENT'S NAME _____ BIRTH DATE _____ SEX _____ GRADE _____
 LAST FIRST MIDDLE
 CITY _____ SCHOOL _____ PLACE OF BIRTH _____
 STREET _____ CITY _____ ZIP _____
 PARENT(S) NAME _____
 ADDRESS (IF DIFFERENT THAN STUDENT) _____ STREET _____ HOME TELEPHONE NO. _____
 CITY _____ ZIP _____
 FAMILY PHYSICIAN'S NAME, ADDRESS, PHONE NUMBER _____

ATHLETE'S HISTORY		YES	NO
1. HAS THIS ATHLETE EVER HAD HOSPITALIZATION, SURGERY, INJURY, OR SERIOUS MEDICAL ILLNESS?	_____	_____	_____
2. IS THIS ATHLETE NOW UNDER THE CARE OF A PHYSICIAN OR TAKING ANY MEDICATION?	_____	_____	_____
3. HAS ANY PHYSICIAN EVER RECOMMENDED OR DO YOU FEEL THAT THERE SHOULD BE LIMITS PLACED ON PARTICIPATION IN COMPETITIVE SPORTS?	_____	_____	_____
4. DOES THIS ATHLETE HAVE ANY KNOWN ALLERGIES TO MEDICATIONS?	_____	_____	_____
5. DOES THIS ATHLETE WEAR GLASSES OR CONTACT LENSES? GIVE DATE OF LAST EYE EXAM IF "YES"	_____	_____	_____
6. HAS THIS ATHLETE EVER BLACKED OUT OR LOST CONSCIOUSNESS DURING PHYSICAL ACTIVITY?	_____	_____	_____

IF YES, PLEASE SPECIFY _____

WE CONSENT TO THE PARTICIPATION OF THE ABOVE-NAMED STUDENT IN THE INTERSCHOLASTIC PROGRAM OF HIS/HER SCHOOL INCLUDING PRACTICE SESSIONS AND TRAVEL TO AND FROM ATHLETIC CONTESTS. WE ALSO AGREE TO EMERGENCY MEDICAL TREATMENT AS DEEMED NECESSARY BY THE PHYSICIANS DESIGNATED BY SCHOOL AUTHORITIES. WE HAVE READ AND UNDERSTAND THE OHSAA ATHLETIC ELIGIBILITY INFORMATION BULLETIN.

STUDENT _____ PARENT _____ DATE _____
 3/95 HISTORY AND CONSENT MUST BE COMPLETED PRIOR TO THE PHYSICAL EXAMINATION.

HEALTH EXAMINATION CARD

STUDENT'S NAME _____ GRADE _____
 HEIGHT _____ WEIGHT _____ BP _____ PULSE _____

ABNORMAL PHYSICAL FINDINGS (INCLUDING INFECTIOUS, CONTAGIOUS, OR CARDIOVASCULAR DISEASES):

DATE OF EXAM _____

OPTIONAL TESTS

URINALYSIS
 ALBUMIN _____
 SUGAR _____
 MICRO (IF ABOVE TEST ABNORMAL) _____

BLOOD COUNT
 HGB. _____
 OR
 HCT. _____

ORAL EXAM _____

SHOULD THERE BE ANY LIMITATIONS PLACED ON ATHLETIC PARTICIPATION? YES _____ NO _____

RECOMMENDATIONS:

I certify that I have on this date examined this student and that, on the basis of the examination requested by the school authorities and the student's medical history as furnished to me, I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities (NOTE EXCEPTIONS ABOVE)

PHYSICIAN'S NAME AND ADDRESS (STAMP OR PRINT) _____ PHYSICIAN'S SIGNATURE _____
 PHYSICIAN'S TELEPHONE NO. _____

(HISTORY AND CONSENT MUST BE COMPLETED PRIOR TO PHYSICAL EXAMINATION)