SCHOOL PHYSICAL EXAMINATION West High School

HEALTH HISTORY (Must	be completed and signed by	y parent prior to	examination):		
GRADE: ATHLE	ETIC PROGRAM IF STUDE	NT PARTICIPAT	ES IN ATHLETI	CS:	
Last Name	First Name	M.I. Grad	le Age	Birth Date	Male or Female
Address			City		Zip Code
HEALTH HISTORY (To be com	pleted by student & parent):				
Check "yes" or "no" and give as m	uch information as possible.				
Heart Trouble	High Blood Pressure		Asthma		Diabetes
	Head Trauma		Seizures		Other
History of any previous injuries, fra	ctures, serious illnesses or operat	ions (Give year of p	problem)		
Current medications		Allergies	Date of Last Tetar	nus Shot	
Signature of Parent or Guardia	n:				
PHYSICAL EXAMINATION	TO BE COMPLETED BY	PHYSICIAN :			
		_	\		
Visual Acuity (Distance): O.D	/O.S/	() Corrected () Uncorrected	LMP_	
Ht Wt	Temp	B/P	Pulse	Resp	irations
1. Eyes	Normal	10 Mus	sculoskeletal ROM	Strength	Normal
2. Ears, Nose, Throat			Neck	Suchgui	
3. Mouth and Teeth			Spine		
4. Neck			Shoulders	-	
Cardiovascular		Arms/Hands			
EKG results if done			Hips		
6. Chest and Lungs			Thighs		
7. Abdomen			Knees		
8. Skin			Ankles		
9. Genitalia-Hernia (male)			Feet		
CICNIEICANE INCEODA E	NIN DI CC	11. Neu	romuscular		
SIGNIFICANT HISTORY FI	INDINGS:				
() Chest Pain () Extreme S.	O.B. () Dizziness () Fa	tigue () Pal _p		of family member of successions of sudden Death	
Other:					
()]	Full Activity - No restrictions (No contact sports () No Participation	estrictions:		
EXAMINING PHYSICIAN:	Name		Signatu	ıre.	
Printed or stamped	Name:Address:	Signature: PHONE #:			
	Address: LICENSE#:		PHONE #:		
DATE OF EVANA					
DATE OF EXAM:					
Revised 08/10					