REQUIRED PHYSICIAN'S EXAMINATIONFOR ATHLETIC PARTICIPATION

NOTRE DAME HIGH SCHOOL
1540 Ralston Ave. Belmont, CA 94002-1995 (650) 595-1913 Fax: (650) 595-1414

Name: _____ Birth date: _____ Grade: _____
Last First

	Yes	No		Yes	No
Head Injury			Ulcers, colitis, or other stomach problems		
Bone/Joint Disorder			Kidney or bladder problems		
Broken Bones/Fractures			Hernia		
Dislocations			Allergies/Skin Problems		
Eye or Ear Problems			Allergic to bee stings		
Fainting or Convulsions			Epi-Pen Needed		
High or Low Blood Pressure			Heat or Muscle Cramps		
Anemia, Leukemia or Bleeding Disorder			Heat Exhaustion or Stroke		
Diabetes			Mental Illness		
Insulin Needed			Tetanus Booster Date:		
Surgery:			Please explain:		
Other Illness:			Please explain:		
Have you had any new injuries since your last physical:			Please explain:		
Are you currently taking any medications:			Please name them and their use:		
Are you allergic to any medications, insect stings, etc?			Please explain:		

PHYSICAL EXAMINATION

Weight:	Height:	Blood Pressure: /	Pulse:	
Vision: Right – 20/	Left – 20/	Vision Corrected: N/A	Right – 20/	Left – 20/

	Normal	Abnormal		Normal	Abnormal
Heart			Neck		
Lungs			Shoulder		
Skin			Elbow		
Abdomen			Wrist/Hand		
Genitalia			Back		
Neurolgic			Knee		
Musculoskeletal			Ankle/Foot		

	Yes	No
Cleared for Sport Participation:		
Limitations:		

_____ _____
Signature of Physician **Date**

PLEASE PRINT OR STAMP NAME and ADDRESS:

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